CHAPTER 24

WELFARE

(Sponsor: NAVY PEOPLE-PS RN FPS HQ CW SO1)

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CHAPTER 24

WELFARE

SECTION 1

PRIMARY LEVEL WELFARE

2401. Introduction

a. Tri Service Operational and Non-Operational Welfare Policy, JSP 770, summarises that:

> *'The nature of military activity and way of Service life set Armed Forces communities apart from many areas of civilian society. The critical connection between welfare and operational effectiveness affirms that the support provided for Service personnel and their family is "core" Armed Forces business.'*

b. There exists clear guidance to all Services regarding the management, development, and provision of welfare. JSP 770 recognises the necessity for single service guidance to reflect the uniqueness of each service, the needs of its personnel and their families, the differing demands placed upon staff and the diversity of working environments that Service Personnel operate within.

c. Responsibility for developing welfare policy for the RN rests with Director People and Training (Dir P&T) who is a member of the Service Personnel Board (SPB). Whilst Dir P&T has responsibility for policy, implementation rests with the chain of command. Hd of People Support is responsible for the collation of welfare policy, although other desks within the P&T Directorate are sometimes responsible for its actual development.

2402. Welfare Provision

a. Welfare is provided by a number of organisations, both within the Command structure and externally through partner organisations and Local Authority agencies (see Section 8 of this Chapter, and Chapter 32) where appropriate. Provision can be defined as either one of two distinct levels of support.

(1) **Primary.** Primary welfare support is defined as the provision of support generally available from within unit resources. Primary welfare level support can be given by Commanding Officers, the Chain of Command, Divisional Officers and the unit pastoral and medical personnel.

(2) **Secondary.** Secondary, specialist, welfare support is defined as that which cannot or should not be dealt with at the primary or unit level since it requires specialist trained staff. Within the Royal Navy such support is provided by Royal Navy Family & People Support (RN FPS).

b. **Maritime Reserves Personnel.** Welfare support, including secondary (specialist) level welfare, for Maritime Reserves and their in-scope families, when mobilised, should be aligned as closely as possible with that offered to regular Service personnel to ensure that the specific needs of the reservist are met. This is to include the support required by reserve forces and their entitled families before, during and after mobilisation. Refer to JSP 753 (Tri-Service Regulations for the Mobilisation of Reservists).

2403. Command Responsibility

Welfare is a key function of command. The Commanders-in-Chief and theatre Commanders overseas are responsible for implementing policies within their own commands. In addition, there exists a number of agencies with specified roles to play that must be recognised and supported by the chain of command. The effectiveness of welfare support is dependent upon the direction and co-ordination of the work of the various specialist agencies, charities and volunteer groups (see Section 8 and Chapter 32) at the appropriate (normally local) level. This is to be achieved through a formal structure of welfare management committees and reinforced, where practical, by the co-location of specialists, services and activities. A Community Partnership Working Group (CPWG) should be in place to support the collaboration between RN FPS, charitable organisations, and partners that deliver community support activities to the service community. Unit budget managers should be consulted to ensure that public funds are only committed to MOD funded welfare elements and that value for money and affordability issues have been fully considered.

2404. Commanding Officer's Responsibility for Personnel Under Their Command

a. Welfare support to all unit Service personnel and the Service community is the responsibility of the CO. This responsibility is exercised through the chain of command, utilising specialist advisers and welfare workers, and by providing community support assets.

b. Commanders at all levels are to undertake the following:

(1) Provide and maintain as a minimum the standard of welfare and community support assets as detailed in JSP 770 Chapter 1, Annex D.

(2) Establish a stigma-free welfare culture that encourages personnel to seek support at the earliest opportunity through the Chain of Command or directly through specialist welfare personnel.

(3) Provide or ensure access to welfare resources where normal civil society does not meet the need.

(4) Ensure that all appropriate personnel undergo training suitable to meet their welfare responsibilities.

(5) Ensure that all vital information, including full details of welfare and community support services, is communicated effectively to the Service community in a way that is suitable to meet their individual needs, as identified in 2436 The Royal Navy Forum (https://forum.royalnavy.mod.uk) This is to include details of the MOD Equality and Diversity Policy, RN Diversity and Inclusion policy (see Chapter 30) and the MOD Unacceptable Behaviour Complaints Procedures (see JSP 763 and JSP 831), ensuring that the welfare needs of the parties to a complaint (complainant and respondent) are properly considered and that they are protected from the stresses of their situation, see JSP 770 Chapter 1 Annex D.

(6) Seek specialist support where necessary. Timely advice and guidance should be sought from higher authority where required. Potentially high profile and contentious issues should be referred to higher authority for consideration before unit action is taken.

(7) Maintain a close working relationship with specialist welfare organisations (i.e. RN FPS), granting suitable access where required. The CO is to regularly hold formal welfare conferences run by specialist welfare staff to address current welfare issues and ensure that a seamless and coherent welfare service is available.

(8) Institute a Carers' Forum, making use of the guidelines in Annex 24B. and develop a Community Partnership Working Group (CPWG) in collaboration with RN FPS, charitable organisations, and partners that deliver community support activities to the service community.

(9) Include welfare requirements within preparations for all exercise and operational deployments, ensuring contact is made to the RN FPS Deployed Asset Team; this should apply equally to mobilised reservists attached to the unit.

(10) Publish a Welfare Charter that sets out the unit welfare strategy. As a minimum, the document should cover: delivery, responsibility and funding framework. An example is at JSP 770 Chapter 1, Annex D.

(11) Disseminate, as part of the induction process for personnel newly arrived at a unit, the following information as a minimum:

(a) Details of the welfare Chain of Command. Personnel should be made fully aware of whom they or their families can contact.

(b) Assurances that the unit is a stigma-free welfare environment.

(c) MOD’s Equality and Diversity policy and RN Diversity and Inclusion policy (see Chapter 30) and the MOD Unacceptable Behaviour Complaints Procedures (see Chapter 23).

(d) Details of welfare facilities both on and off base. These should include the RN FPS Information Support Office (see Para 2456,) and community centre; education and sports facilities; social and retail facilities; and youth and childcare facilities and activities, and the RN Forum.

(e) Details of the Unit Welfare Charter in accordance with JSP 770 Chapter 1 Annex D.

2405. Welfare Within Ship, Submarine, Unit or Establishment

a. **Personnel.**

(1) **Chain of Command.** Welfare is a key function of command and, as such, COs have full responsibility for the welfare of the personnel and the Service community under their command.

(2) **The Divisional Officer (DO).** The primary duties of DO include knowing their personnel and being responsible for their pastoral care and morale (for divisional matters, see Chapter 21 and BRd 2 Chapter 18).

(3) **Unit Medical Staff.** Medical staff are present on all major military establishments and provide primary healthcare to all Service personnel and where applicable their families. For medical matters, see Chapter 28.

(4) **Chaplaincy (including Civilian Chaplains to the Military (CCMs)).** All Chaplains are to be actively involved in primary welfare support, principally in the context of pastoral care. Whilst they cannot offer specific religious care to members of a faith group different from their own or to those with no religion or belief, they are to offer independent advice and support to all personnel, including details of local faith group communities and centres of worship. They are to offer confidentiality according to their own Church discipline, advice and emotional support to all members of the Armed Forces and their dependants regardless of faith. The Armed Forces have appointed religious leaders (Civilian Chaplains to the Military (CCMs) from the Buddhist, Hindu, Jewish, Muslim and Sikh faiths) to act as advisers on matters specific to those faiths. For further information on religion and belief, see Chapter 31.

(5) Specialist Welfare Workers (employed within RN FPS). See Para 2412.

(6) **Community Development Workers (CDW) (employed within RN FPS).** See Para 2434.

(7) **Diversity and Inclusion Advisers (D&I(A)s).** All Service units and establishments are required to have least two D&I(A)s (an increasing number have a network of D&I(A)s and D&I(P)s), who are available to provide impartial advice on all aspects of Diversity and Inclusion and, in particular, procedures for making complaints of discrimination, harassment or bullying. See Chapter 30.

(8) **RN FPS Information Officers.** Employed within RN FPS . See Para 2435.

b. **Welfare Committee.**

(1) The institution of a Welfare Committee is in no way to interfere with or prejudice the right of an individual to put forward suggestions through the DO, nor to affect the responsibility of the DO for looking after the interests of those in the division.

(2) The items which Welfare Committees may discuss include living conditions in the ship, submarine or establishment, messing arrangements, recreational activities and any suggestions for the welfare of the ship's company. Responsibility for the administration of the ship's funds will also be undertaken by the committees (see Annex 24A).

(3) General conditions of the Royal Navy, such as discipline, working hours, pay, allowances and leave scales and such matters as cooking and serving food from galleys, are outside the scope of the Welfare Committee.

c. **Personnel Under 18 and Recruits.** The policy regarding the management and welfare of recruits and Service personnel under 18 years of age is contained in JSP 834 and Chapter 21. This policy provides additional advice to COs regarding the legal requirements associated with Service personnel aged Under 18 and, whilst maturity and experience vary considerably between individuals, it is clear that under 18s may be more vulnerable than those who are older, and their care may require particular attention.

d. **Care Leavers.** There will also be individuals joining the Armed Forces who are care leavers and therefore subject to the provisions of the Children (Leaving Care) Act 2000. This seeks to ensure that young people aged 16-21 years, or older, if in an agreed training or education programme, or who have had a significant period of being looked after by a Local Authority (LA), continue to receive advice, support and befriending for a period of time after they cease to be formally the full-time responsibility of the LA. Under 18s who are care leavers may not have the benefit of family support that others enjoy; this may make them more vulnerable. COs are to follow the advice contained in JSP 834.

2406. Preventative Welfare - Definition

The term 'preventative welfare' is used to describe the work of promoting the wellbeing of individuals and families before problems become evident, of limiting the intensity and duration of problems that arise, and of supporting existing problems in order to reduce future distress and limit further damage. Through communication with members of their Division, Divisional Officers can play a key part in preventing or reducing difficulties from arising.

2407. Welfare Provision to Service Personnel and Their Families

Although it is not always practical to provide the same welfare support to those who reside away from their unit, COs are to ensure that, at the very least, such personnel are presented with a comprehensive welfare information package. The package should include, as a minimum, contact details of the relevant welfare specialists, advice on what to do in given circumstances and the on-line options available. The Royal Navy Forum (https://forum.royalnavy.mod.uk) provides a safe and secure environment for this information, see 2436 para d.

2408. Deployed Welfare Support (DWS)

a. DWS is delivered by the Deployment Welfare Package (Overseas) (DWP(O)) or the Deployment Welfare Package (United Kingdom) (DWP(UK)). Full details are contained within JSP 770; however, the fundamental principles of operational welfare are as follows:

(1) Welfare support is intended to enhance and sustain operational effectiveness.

(2) Operational need has priority over individual welfare.

(3) The aim of welfare spending is to make sufficient provision for personnel welfare such that an individual can concentrate on the operational task in hand.

(4) The welfare of Service personnel is a Command function and key to sustaining the moral component. It is also important to ensure that individuals feel that their needs have been looked after from the perspective of job satisfaction and, ultimately, retention.

(5) There must be a level playing field wherever possible such that all Service personnel know and understand what support is available to them and that no group feels disadvantaged in comparison to another.

(6) In general terms, the provision of DWS means that individuals should not be disadvantaged financially or by lack of access to welfare facilities when deployed.

(7) Harmonised, common and agreed tri-Service procedures should be applied rather than ad hoc single Service solutions. Disparity in terms and conditions between personnel from different Services on operations have previously been identified as a significant irritant and must be eliminated wherever possible.

b. DWS seeks to achieve the following effects.

(1) **Communicate.** To enable deployed Service personnel to retain contact with family and friends.

(2) **Entertain.** To provide for the leisure and relaxation needs of deployed Service personnel.

(3) **Support.** To provide for the physiological needs of deployed Service personnel.

(4) **Connect.** To provide support for the families of deployed Service personnel and facilitate the Service person's reintegration into the family unit.

c. The components of the DWP(O) are:

(1) **Communication.**

(a) Provision of telecommunications.

(b) E-mail and SMS Texting.

(c) Forces mail.

(2) **Entertainment.**

(a) Audio visual.

(b) Internet.

(c) Printed matter and games.

(d) Combined Services Entertainment (CSE).

(e) Operational Fitness Equipment.

(3) **Support.**

(a) Shops (EFI and NCS).

(b) Laundry and shower facilities.

(4) **Connect.**

(a) Families Welfare Grant.

(b) Families Concessionary Travel Allowance.

(c) Rest and Recuperation.

(d) Post Operational Leave.

2409. Welfare Provision for Operational Deployments Within the UK

a. Full details are contained within JSP 770 Part 1 Chapter 6.

b. UK-based operations are primarily focussed on Military Aid to Civil Authorities (MACA). This includes:

(1) **Military Aid to the Civil Powers (MACP).** MACP is defined as support to the civil powers in the maintenance of law, order and public safety (e.g. support to counter terrorism operations).

(2) **Military Aid to Other Government Departments (MAGD).** MAGD is defined as assistance on urgent work of national importance or in maintaining supplies/essential services, e.g. Op FRESCO (provision of fire service support).

(3) **Military Aid to the Civil Community (MACC).** MACC is defined as the provision of unarmed military assistance in the event of a localised natural disaster or major incident, e.g. severe flooding.

c. Operations in Afghanistan identified a need to provide DWS for those Service personnel deployed in the UK in support of overseas operations.

d. **Eligibility Criteria.** The policy is designed for those Service personnel (regular and reserves) deployed away from their base location in formed and non-formed units (including augmentees who will, by and large, 'bulge' an existing establishment infrastructure) in support of:

(1) A MACA operation which has:

(a) An operational name;

(b) Is supported by a CDS directive and/or has MOD Ministerial authorisation;

(c) Is expected to last for seven days or more from the date of deployment or pre-training.

(2) Those Service personnel deployed away from their base unit in support of an overseas operation (for which DWP(O) is authorised and is supported by a CDS directive) but remain in the UK.

e. **DWP(UK) Provision.** DWP(UK) policy mirrors the principle adopted in the DWP(O) for overseas operations in that welfare support should be publicly funded. Unlike the DWP(O), which by and large requires an infrastructure to be put in place, e.g. telephones, internet, post, recreational facilities, etc. DWP(UK) aims to utilise the existing infrastructure in the UK.

2410. Other Welfare Funding

a. **Commanding Officer's Fund.** The Commanding Officer's Fund has traditionally been used to promote the smooth running and efficiency of a unit by purchasing items not normally available through the supply chain. BRd 18 should be referred to for further details of the operation of the CO's Fund.

b. **Gainshare Policy.** Under PAYD (Catering Retail and Leisure (CRL)), an element of profit made by the Commercial partner is returned to the MOD as 'gainshare'. Gainshare monies can be used by Commanding Officers to enhance welfare provision at unit/station level. The gainshare return will be split between the non-public and public funds on ratio 2:1 basis (⅔ non-public funds and ⅓ public). Commanders have a great deal of flexibility, within the single Service rules and regulations relevant to non-public funds, in the way that they utilise the non-public element of gainshare.

2411. Welfare of Parties to Unacceptable Behaviour Complaints

Refer to Chapter 23, JSP 770 Chapter 1 Annex D and JSP 763/JSP 831 (MOD Unacceptable Behaviour Complaints Procedures).

SECTION 2

SECONDARY (SPECIALIST) LEVEL WELFARE

2412. Royal Navy Family & People Support (RN FPS)

a. **Introduction.** Unless specifically stated the following provision applies to all RN/RM personnel, including mobilised reservists, and their families. The nature of military activity and way of Service life set Armed Forces communities apart from many areas of civilian society. The critical connection between specialist welfare and operational effectiveness affirms that the support provided for Service personnel and their families is 'core' Royal Navy business.

b. Accordingly, the RN FPS Mission Statement is:

'To provide accessible support services that strengthen and enhance the resilience and resourcefulness of Royal Navy and Royal Marine personnel, their families and communities in order to contribute to the Moral Component and optimise Operational Capability.'

c. RN FPS provides personal support, information and community-based support services to all RN personnel, reservists, and their families. RN FPS works in partnership with the Executive, Divisional and Regimental System to provide professional advice, support and recommendations to COs, including outcomes of investigations relating to compassionate action. RN FPS seeks to develop and deploy resources to anticipate and prevent personal or family circumstances from reaching crisis point and which promote improved morale, motivation and wellbeing. RN FPS has four key priorities:

(1) Deployment Support.

(2) Visiting Officer role.

(3) Crisis Intervention.

(4) Safeguarding.

These are achieved via three Pillars of Delivery:

(1) Casework.

(2) Community Development.

(3) Communication, Engagement and Information Support.

d. **RN FPS Organisational Structure.** The RN FPS is a multi-disciplinary and mutually supportive organisation which provides services for all RN and RM personnel and their families to ensure equal access to all.

(1) RN FPS Portal Team is the primary point of entry for specialist welfare i.e. investigations, assistance and assessments (Tel: 0800 145 6088/, email: navypeople-psrnfpsportal@mod.gov.uk

(2) Para 2414 sub para a. provides the information required by the Portal team to initiate an assessment or compassionate investigation. Area teams may undertake assessments on behalf of the Portal team, retain walk-in facilities and provide localised support for cases which are assessed as more complex and/or require face to face support, potentially including multi-disciplinary working.

(3) RN FPS offices are embedded into the local unit command structure and provide the professional lead.

(a) **Service Delivery 1.** Has main offices in HMS NELSON (RN FPS, Swiftsure Building, HMS NELSON, Queen Street, PORTSMOUTH PO1 3HH. Email: navypeople-psrnfpseast@mod.gov.uk) & Helensburgh (RN FPS, Triton House, 1-5 Churchill Square, HELENSBURGH, G84 9HL. Email: navypeople-psrnfpsscot@mod.gov.uk). Has satellites in Northwood HQ, Gibraltar, HMS SULTAN/COLLINGWOOD, RM Hamworthy, HMS EAGLET, HMS CALLIOPE, RAF Marham, 43 Cdo and 45 Cdo.

(b) **Service Delivery 2.** Has main offices in HMS DRAKE (B149, HMS DRAKE, HMNB Devonport, PLYMOUTH, PL2 2BG. Email: navypeople-psrnfpswest@mod.gov.uk) & RNAS Yeovilton (Somerset Court, RNAS Yeovilton, Ilchester, Somerset, BA22 8HT. Email: navypeople-psrnfpscent@mod.gov.uk). Has satellites in RNAS Culdrose, HMS RALEIGH, BRNC Dartmouth, 42 Cdo RM, RMBS Stonehouse/30 Cdo RM and the Royal Navy Recovery Pathway Hasler, HMS FORWARD, CLR, CTCRM and 40 Cdo.

e. Overall responsibility for the RN FPS specialist welfare provision, delivery and professional standards lies with the Hd of FPS, who is accountable to Hd of People Support. Email: navypeople-psrnfpshq@mod.gov.uk

f. When working directly with their service users, RN FPS military personnel are authorised to work without the use of rank or rate; they are, however, to adhere to Service protocols and appropriate marks of respect are to be applied at all times when dealing with the Chain of Command, and those within the Divisional/Regimental system. When working face to face with service users, RN FPS personnel are authorised to wear smart and appropriate civilian clothing in accordance with JSP 752.

g. **RN FPS Services.**

(1) A comprehensive, confidential (see para 2413), specialist welfare service to Service Personnel and their families.

(2) A professional service to the Executive, Regimental and Divisional System.

(3) Compassionate assessments, investigations and recommendations.

(4) A link between the Service person and their family in times of crisis or need.

(5) Provision of Visiting Officers (VOs) in accordance with JSP 751.

(6) Delivery of a timely, high quality, and effective service without discrimination.

(7) A professional link to external agencies, e.g. Local Authorities.

(8) A high-quality information service, both face-to-face and across several digital platforms - see Para 2436.

(9) A network of community activities, organised and bespoke, including the critical area of deployment support.

h. For the vast majority of cases, RN FPS can work alongside the Service person/NoK to achieve solutions without the need to recommend compassionate action.

2413. Confidentiality

The RN FPS code of confidentiality means that disclosure of confidential information should only take place if consent to share from the individual has been obtained. However, if prior permission from the individual is not given, and there might be serious consequences of not disclosing confidential information, the matter should be referred to higher authority for advice. For example, such circumstances might include the following:

a. Where there is a risk of harm to the individual or others. When assessing risk, it is essential to consider fitness for armed duties (i.e. access to or overseeing firearm(s)), when deciding on disclosure of information to the Chain of Command. Any concerns relating to an individual's fitness for armed duties must be disclosed to the Chain of Command and line managers and be recorded in the RN FPS case notes.

b. In order to prevent a serious criminal act.

c. If there is a serious contravention of military law.

d. If there is, or is likely to be, a serious breach of national security.

e. If an individual is unable to carry out their duties.

f. If there are concerns relating to adult or child safeguarding issues, domestic abuse or gender-based violence (including female genital mutilation (FGM)).

g. Any such disclosure must be in line with relevant privacy notices and the MOD's Personal Information Charter.

2414. Referral to RN FPS

a. Initial access to RN FPS should, where possible, be via the Portal (Tel: 0800 145 6088, Navypeople-psrnfpsportal@mod.gov.uk, each of which can be used to initiate/request a compassionate investigation/assessment. CoC requests for compassionate investigations should include the following information:

(1) Serving Person: full name, rank/rate, service number and unit;

(2) Address to be visited/contacted (including key contact and telephone numbers);

(3) Summary of situation: any previous compassionate action (e.g. compassionate leave); relevant contact details of NOK, extended family, professionals and organisations;

(4) Impact on the unit if the Service Person is granted compassionate action;

(5) Point of contact within Divisional/Regimental System.

(6) Consent granted by the Serving Person for RN FPS involvement

b. Urgent specialist welfare support outside of RN FPS daily opening hours can be accessed through OOW HMS NELSON (Tel: 02392 723875), OOW HMS DRAKE (Tel: 01752 555220), Duty Naval Base Officer Faslane (Tel: 01436 674321 Ext 4005) and Officer of the Watch RNAS Yeovilton (Tel: 01935 455444/5446).

c. **Tri-Service Arrangements.** The provision of specialist welfare support is a responsibility of the parent Service Command (in accordance with JSP 770) but there will be occasions when another service welfare provider (e.g. the Army Welfare Service) is able to meet the needs of a service user more effectively. The Tri-Service Specialist Welfare Agreement on mutual working and areas of responsibility (Annex 24F) applies. Compassionate action, assignments, discharge or services provided at public expense must involve the parent Service Chain of Command.

d. A referral for RN FPS casework services will result in a casefile being created and personal data being stored on a computer application (Joint Army Navy Information System (JANIS)), which is Data Protection Act (2018) compliant and registered on the Navy Command Information Asset Register.

SECTION 3

SPECIFIC WELFARE POLICY AND GUIDANCE

2415. Specific Welfare Policy and Guidance

A number of areas of welfare are covered by specific policy. This is covered in the following paragraphs.

2416. Events with Potential Media Interest

a. The appetite for news and the prevalence of social media means that the Chain of Command (CoC) should consider the implications of initial (incident) and subsequent related events (reports, court cases, appeals, inquests, etc.) on personnel and their families. This primary welfare responsibility extends beyond the personnel directly involved to those peripherally associated with the event and their families. There have been examples of media trawling housing estates and schools in an attempt to identify individuals connected, even indirectly, with an incident or unit. The role of the CoC is to consider the potential impact of the event on the people affected and put in place proportionate communications and support strategies.

b. The scale and characteristics of these events and the commensurate response will vary considerably, and each will require a bespoke approach. A multi-disciplinary perspective is recommended and the CoC should consider engaging with People Support (RN FPS, Operational Stress Management, media, Service Police, legal and secretariat advisers as appropriate). A mapping exercise to identify potential areas of focus may also be considered (see also Chapter 20 Section 17 - Civil Offences and Section 22 – Management of Convicted and Suspected Sex Offenders).

2417. Vulnerable Risk Management Information System (VRMIS)

The procedures for the management of Service personnel who may be ‘at risk’ are contained in Annex 24C.

2418. Deliberate Self-Harm (DSH) or Suicide

a. The procedures for management of DSH is contained in Annex 24D with associated appendices, which cover the following: sources of advice and support; an algorithm for Executive management of DSH; Case Conferences – Guidance for Medical Officers.

b. Action to be taken on discovery of a death or serious injury in an establishment is at Annex 24E.

2419. Relationship Breakdown

a. Relationship breakdown includes marriage and civil partnerships as defined for Service personnel in JSP 752. Couples who form a civil partnership and register the partnership under the terms of the relevant legal regulations have the legal status of “civil partner”.

b. When a couple realises that there are serious difficulties in their marriage/civil partnership they should try consulting with a suitably qualified person, third party or organisation such as RN FPS (see Para 2412), Relate (see Para 2463 and Chapter 32), or a Chaplain (see Chapter 31 and BRd 2) to take advice on their concerns and consider appropriate intervention before starting divorce proceedings.

c. Service Personnel in PStat Cat 1C/S, whose marriage or civil partnership has broken down, or estrangement is imminent, may take advantage of a 'cooling off' period. A period of up to three months may be allowed to permit counselling and a possible reconciliation before a change in PStat Cat is required. If no reconciliation has been achieved by then (or at an earlier stage if it becomes clear that no reconciliation is possible) the PStat Cat should be changed from that date. Details regarding responsibility for change of PStat Cat are contained in JSP 752.

d. Further details and information relating to SFA and SLA accommodation charges and entitlements are contained in JSP 464 Volume 1 Chapter 3 (Para 0349 relates to Estrangement) and JSP 464 Volume 2 Part 1 respectively. Details relating to accommodation charges are contained in JSP 464 Volume 3.

e. Where a relationship is considered to have irretrievably broken down but difficulties remain to be resolved, the use of conciliation services may prove beneficial. Conciliation services provide a means of resolving actual or incipient issues, clarifying confused situations, and reducing conflicts by mediating between partners; usually before formal proceedings begin and before contact through legal representatives has hardened attitudes. Conciliators will aim to foster good future parent/child relationships.

f. Information for Divisional Officers, including with regard to financial implications, is at Chapter 21 Section 7; and Annex 21R provides a proforma for a structured interview before change of PStat Cat.

2420. Domestic Abuse (Including Domestic Violence)

a. JSP 913 is the tri-Service Policy on Domestic Abuse and Sexual Violence.

b. The Information Sharing Agreement between the Royal Navy Police and RN FPS covering the sharing of information surrounding referral of victims of domestic abuse, honour-based and sexual violence and the safeguarding of adults and children is available on request from either organisation.

2421. Child Care

a. OFSTED[1] provides details of the defence Wraparound Childcare (WAC) scheme is available via the Defence Childcare Portal accessible via defnet and was rolled out across the UK in September 2022. WAC provides families with better flexibility and affordable childcare support.

[1] http://www.gov.uk/government/organisations/ofsted

b. JSP 770 Chapter 3 provides MOD Policy applicable to all officially recognised youth and play activities provided through the medium of MOD youth centres, youth clubs, projects, play centres, community services, activity centres, and gymnasiums. See 2025DIN08-009 : Activities that are not covered by the MOD's self-insurance arrangements – non-core business activities).

c. Youth and play activities may be provided for RN/RM dependants in each of the base port areas as well as in certain other bases/units. The National Community Development Manager (NCDM) acts as professional adviser to the base/unit CO and who maintains standards under the policy direction of RN FPS Head of Department. Wherever possible, activities are carried out in conjunction with the relevant local authority.

2422. Safeguarding Children

a. JSP 834 contains the Tri-Service Policy on Safeguarding and should be followed at all times. The Ministry of Defence (MOD) and Department for Education (DfE) are committed to working together to ensure the safeguarding of Service children and young people. Further guidance in all areas of safeguarding can be found in the DfE's Working Together to Safeguard Children.

b. **Child Protection.** In UK, all child protection concerns and referrals must be referred to, and dealt with by, the statutory authorities. RN FPS can offer advice and assistance in this process however; the needs of the child are paramount and immediate and serious concerns should be reported to the Civil Police and/or social services to ensure that the child is protected without delay. All child protection matters within the Royal Navy should be notified to the RN FPS Portal or the local RN FPS Service Manager.

c. The Information Sharing Agreement between the Royal Navy Police and RN FPS covering the sharing of information surrounding referral of victims of domestic abuse, honour-based and sexual violence and the safeguarding of adults and children is available on request from either organisation.

2423. Disability and Additional Needs

a. 2025DIN01-114-Armed Forces Carers Passport Guidance and Implementation.docx - The Carer's Passport facilitates and records discussions between a Service Person with caring responsibilities and their manager to balance caregiving duties with work and operational responsibilities. This is retention positive and enhances operational effectiveness.

b. Tri-Service Accommodation Regulations (TSARs – JSP 464 Volume 1 Part 2 Chapter 6 Annex C - provides details of the Additional Needs and Disabled Adaptations (ANDA) for Service Families Accommodation.

c. The Forces Additional Needs and Disability Forum (FANDF) is a tri-Service group for Serving personnel, reservists and their families who have a child or adult immediate family member with an additional need and/or disability. They also produce a useful guide.

d. The Royal Navy Forum holds useful information within the topical area and the RN FPS Portal is available to assess, advise and assist on individual circumstances. Tel: 0800 145 6088. Email: navypeople-psrnfpsportal@mod.gov.uk.

e. The Education Advisory Team (UK) (EAT (UK))is a service located within the MOD's Directorate with Defence Children Services (DCS) which is established to provide information, advice and support to Service parents about any issue relating to the education of their children, both in the UK and overseas. Much of the demand for the services offered by EAT (UK) comes from Service parents who have children with special educational needs (SEN) and, in Scotland, additional support needs (ASN).

2424. Sex Offenders

The management of convicted or suspected sex offenders in the Service is detailed in Chapter 20, Section 22.

2425. Adoption and Fostering

JSP 760 directs Service personnel to the correct policies and guidelines governing adoption and fostering. It should be read in conjunction with relevant Service and Command instructions (including JSP 464).

SECTION 4

COMPASSIONATE ACTION

2426. Compassionate Action

a. There are six types of compassionate action:

(1) Compassionate Leave.

(2) Compassionate Area Restriction

(3) Compassionate Assignment.

(4) Prolonged Shore Assignment.

(5) Permanent Shore Assignments.

(6) Compassionate Discharge.

b. With the exception of Compassionate Leave, all other compassionate actions must be investigated and recommended by RN FPS.

2427. Compassionate Criteria

a. Before RN FPS makes a recommendation to the chain of command for compassionate action, they need to be certain that the Service Person's presence (i.e. at home) is essential and that all other courses of action, feasible options and the opinions of other professionals (as appropriate) have been taken into account and assessed. As part of a thorough and holistic assessment process, it is often necessary for RN FPS to visit family members in their home environment to assess levels of support required.

b. Although no precise guidance can be laid down each case requires objective and holistic assessment. In the following circumstances a recommendation for compassionate action may be deemed appropriate:

(1) When the spouse/civil partner, child or in-scope relative (See JSP 751) of a Service Person is seriously ill or has died;

(2) When a Service Person's presence is the only means of preventing the break-up of their immediate family;

(3) Where the care of dependant/in-scope child(ren) can only be appropriately provided by the Service Person's presence;

(4) At other times when circumstances are assessed to be exceptional and more than usually distressing.

2428. Compassionate Leave

a. Compassionate leave is defined as an authorised period of absence to enable Service personnel to attend a personal/domestic crisis and does not count against an individual's annual leave entitlement.

b. The authorisation and duration of compassionate leave rests with the individual's CO, who may authorise up to 4 full weeks, although 2 full weeks will normally be sufficient in the first instance. Only in exceptional circumstances and following a re-examination of the circumstances should compassionate leave exceed 4 full weeks.

c. CO's, individuals and the chain of command can request support from RN FPS who will assist COs in reaching decisions on compassionate leave by undertaking investigations, making appropriate recommendations, and assisting individuals and families to explore all areas of support. Repeated periods of compassionate leave for the same/recurring situation should rarely be authorised and service personnel would be expected to utilise the welfare support available to resolve or improve their personal situation.

d. Referrals to RN FPS will need to have the consent of the individual concerned and should be offered at the beginning of the compassionate leave period especially when the situation is particularly complicated, or it is apparent that the timings may extend beyond the initial period. Requests for RN FPS investigate assessment can be found at Para 2414.

2429. Compassionate Travel

a. The criteria for categorisation of compassionate travel at public expense are detailed in JSP 751.

b. **Within UK Territorial Waters.** Authority for compassionate leave travel within the UK rests with the Service Person's CO and should only be granted when the circumstances are particularly distressing and a genuine need for travel at public expense (rather than personal) is identified.

c. **Outside of UK Territorial Waters and Units Overseas.** Compassionate travel from outside of the UK territorial waters will normally only be considered if the case concerns 'in-scope' relatives. JSP 751 contains a list of 'in-scope' relatives. The authorisation for compassionate travel at public expense from outside of UK territorial waters lies with the Joint Casualty and Compassionate Centre (JCCC) (www.gov.uk/joint-casualty-and-compassionate-centre-jccc JCCC Tel: 0044+ (0)1452 519951; Service: 95471 7325).

d. **Compassionate Leave Travel to Countries other than the UK.** Domiciled Collective Leave and Commonwealth Enlisted Compassionate Travel (DOMCOL and COMECT) arrangements are detailed in JSP 760.

2430. Compassionate Area Restriction

a. A Compassionate Area Restriction enables an individual to be present when a Service Person's situation falls within the compassionate criteria at Para 2427 but can be gainfully employed during the working day, negating the need for compassionate leave.

b. Recommendations for Compassionate Area Restrictions should be considered only when an holistic assessment has deemed that the Service Person's presence is essential to provide support outside of working hours. Recommendations made should detail working hours achievable by the Service Person for the duration of the area restriction.

c. Compassionate Area Restriction must only be utilised as a short-term measure to provide essential care/support in times of domestic crisis. Recommendations should be considered initially for up to two full weeks and should not exceed four weeks. If exceptional circumstances are present which warrant further area restriction, then the situation should be assessed for compassionate assignment.

d. The authorisation for and duration of Compassionate Area Restriction rests with the individual's CO. RN FPS is to conduct a full investigation and verification and present the CO with a formal recommendation and review date to assist the CO in reaching a decision.

e. Repeated periods of Compassionate Area Restriction for the same/recurring situation should rarely be authorised; service personnel are expected to resolve their personal affairs within a reasonable timescale using the welfare support available to them.

2431. Compassionate Assignments

a. Where Compassionate Leave/Area Restriction is insufficient to resolve a problem, a Compassionate Assignment may be considered. The authority for Compassionate Assignment recommendations rests with RN FPS; it will usually be for up to three months and not more than six months' duration.

b. Commanding Officers or assignment authorities who consider that a Compassionate Assignment may be necessary should request an investigation by RN FPS (see Para 2414). During the course of the investigation RN FPS should, if not already involved, consult with the appropriate assignment authority regarding the implications of a reassignment (e.g. impact on OC of resulting gap). It should be borne in mind that compassionate assignment action to resolve one person's difficulties can frequently disadvantage or significantly disrupt others, especially when a relief is sought at short notice and out of turn.

c. During the course of the compassionate investigation and any resulting action, the Service Person is expected to fully engage with RN FPS, the Divisional/Regimental System and, where appropriate, their allocated Personnel Support Group (PSG) or Recovery Cell. On completion of the investigation, RN FPS will make one of the following recommendations:

(1) Compassionate Assignment is not recommended.

(2) Compassionate Assignment is highly desirable, even though this may seriously interfere with the requirements of the Service.

(3) Compassionate Assignment is essential. This could be for the Safeguarding of children or vulnerable adults within the Service Person's immediate family.

d. The decision to approve the compassionate assignment recommendation rests with the CO, taking into account the Service requirement. In all cases RN FPS and the assignment authority are to be informed of the decision.

e. All Compassionate Assignments are subject to formal written review carried out by RN FPS, which will provide the following:

(1) An assessment of the current situation;

(2) An evaluation of progress to date;

(3) Necessity for the Service Person's continued presence;

(4) Range of options and specific recommendations.

f. The overriding principle is to keep the CO and Career Manager updated with progress and supplied with sufficient information in order to make considered decisions in a timely manner, benefitting the Service Person and the Service. Reviews are to be carried out a minimum of one month before the compassionate assignment is due to expire. Reviews should also be undertaken where there is a significant change to circumstances and the outcome of the review should be shared with the Command and, as appropriate, the Career Manager.

g. RN FPS recommendations should state only the general geographical area to which a person is to be assigned e.g. base port or county. The assignment authority should, wherever possible, seek to place the Service Person in a complement billet where the individual will work within their specialisation.

h. RN FPS should in all cases discuss with the assignment authority and, wherever appropriate and possible, with the receiving Command, any circumstances that may affect or impair the individual's employability whilst in the Compassionate Assignment.

i. Service personnel should be advised that, on completion of a Compassionate Assignment, they are subject to the requirements of the Service. They may return to their former place of duty or, where an assignment has been deferred for compassionate reasons, take up a planned or alternative assignment elsewhere that is within established assigning principles and protocols.

j. The case for an extension to a Compassionate Assignment should be supported by a RN FPS Social Inquiry Report (SIR) and appropriate recommendation by a RN FPS Service Manager. The completed SIR will be despatched to the Commanding Officer holding responsibility for the Service Person who, in turn, will forward a recommendation to the Career Manager (who will have a copy of the full report) for a decision.

k. **Assisted Conception Services.** Guidance for those seeking stability in order to access assisted conception services (including IVF), and those in chain of command and assigning authorities, is at Chapter 60, Para 6015 and 2021DIN01-020 – Assisted Conception services and Fertility Preservation.

2432. Prolonged or Permanent Shore Assignments

a. When a very serious or complex situation cannot be resolved within the limited period of a Compassionate Assignment, consideration can be given to an application for a prolonged or permanent shore assignment, or Compassionate Discharge.

b. When a Compassionate Discharge is not requested by a Service Person or is deemed inappropriate (e.g. within two years of completing relevant pensionable engagement), a case should be made to the CO for a prolonged or permanent shore assignment.

c. Prolonged shore assignments are usually of six to 12 months duration; permanent shore assignments normally cover the last 12 to 24 months of Service before Termination Date.

d. The case for a prolonged or permanent shore assignment must be supported by a Social Inquiry Report (SIR) and appropriate recommendation by RN FPS.

e. SIRs should be completed by RN FPS within a maximum of 20 working days of the initial, formal request from the CO or assignment authority. In exceptional circumstances where situations are complex or contact with professionals involved etc has been difficult to establish then the SIR timeframe can be extended. This will only be done where absolutely necessary. The Serving Person, Command and the assignment authority will be updated formally, in writing, before the end of the initial 20 day period. Extensions can only be authorised by the RN FPS Service Manager /Head of Department and should be authorised in no more than 10 working day intervals.

f. The completed SIR will be sent to the CO who, if content, will forward a recommendation to the assignment authority for a decision. In all cases RN FPS is to be informed of the decision.

g. Where the CO and the assignment authority are not in agreement, completed reports and recommendations are to be submitted to Deputy Director People Delivery (DDPD) for a decision.

h. Prolonged and permanent shore assignments are subject to a formal written review by RN FPS.

(1) Prolonged shore assignments are to be reviewed at least every three months, with a final review a minimum of three months before the assignment is due to expire.

(2) Permanent shore assignments are subject to formal written review at least every six months, with a final review a minimum of three months before termination date to enable consideration for continuing welfare needs in accordance with DBS transitional protocols.

i. When a significant change of circumstances is reported, or the CO or assignment authority requests that a formal review be undertaken, a written report should be completed by RN FPS within a maximum of 10 working days of the report/request.

2433. Compassionate Discharge

a. The full terms and conditions for Compassionate Discharge are detailed in Chapter 54. In circumstances where a Service Person's presence at home is deemed essential and their home circumstances have become wholly incompatible with a continued Service career as a consequence, an application may be made by the Service Person, through JPA, to the CO, for Compassionate Discharge. Compassionate Discharge must be supported by a Social Inquiry Report (SIR) (SIR to be completed within the timeframes laid down in 2432 para e) with a clear recommendation from RN FPS to the CO. In turn, the CO will forward a recommendation to the assignment authority for a decision.

b. In situations where Compassionate Discharge is not recommended, the CO is to forward the case to Navy Legal Casework Cell. A final decision will be made and the outcome passed to the assignment authority.

SECTION 5

COMMUNITY ENGAGEMENT

2434. Community and Engagement Team

a. The Community and Engagement Team consists of Digital, Information, and Community Delivery specialists. They are responsible for the promotion and delivery of a programme of proactive and preventative support for service personnel and their families, in order to enable RNFPS to meet their strategic aims. This team is responsible for:

(1) Managing the Royal Navy Forum which is the Royal Navy's official communication channel between units and their families.

(2) Delivering a variety of on-line and virtual community activities, in partnership with other organisations.

(3) Developing volunteers recruited from the local Service community, Serving personnel, veterans, and their families, in partnership with RNRMC.

(4) RN FPS are responsible for managing a programme of Family Support Activities (FSA), local Forces Families Events (FFE) and Deployment Support Events (DSE), facilitating the delivery of play work, delivering Youth Work in their area of operation.

b. This work is based on a three-tier model of service delivery of universal, targeted and open, targeted and closed. This model is delivered primarily through RN FPS Community Development Workers (CDW) and while the range of provision can vary geographically, it is focused upon the key areas in the Community Policy (as detailed in JSP 770 Chapter 3). In addition, facilities are widely used by other community service providers such as Health Visitor clinics, and Scout and Guide Groups. Details of what is available can be accessed via the RN Forum, RN Website or via email: navypeople-psrnfpscom@mod.gov.uk

2435. RN FPS Information Support

a. **Communication, Engagement and Digital Media.** The Community and Engagement Team manage the Royal Navy Forum, which is the Royal Navy's official and approved communication channel between units and their families, sharing service-related updates, promoting events and activities, and encouraging peer-to-peer support. The team also work closely with a variety of MoD departments and other organisations to ensure engagement and collaborative working where possible. Their main areas of delivery are relocation, deployment and enhanced peer support.

b. RN FPS Information Officers and Digital Moderators offer a confidential and accessible information and guidance service that will answer questions or signpost customers to appropriate sources of information and guidance, researching as required. It is a service for families seeking information on all subjects including local communities, relocation, education, housing, employment/training courses, health, wellbeing and travel. The Information Officers collaborate with RN FPS Deployed Asset Team on deployment support, ensuring units are provided with briefings as well as up-to-date information relevant to deployment. The Digital Moderators manage the RN Forums on behalf of operational units, Training establishments and local RN FPS areas. This service is accessible via email: navypeople-psrnfpsinfo@mod.gov.uk[2]:

2436. Royal Navy Forum

a. The Royal Navy Website contains a set of information pages specific to Families, enabling them to find specific information to support them whilst they are part of a Naval Service Family and beyond as a Veteran Family. These pages will provide links into the Royal Navy Forum. The Royal Navy Forum (https://forum.royalnavy.mod.uk) provides a safe and secure environment for families to be informed, involved and in touch with likeminded individuals and their Service Persons Unit.

b. The Topics area provides open-source information on a wide variety of subjects including deployment, education, health and wellbeing, finance, employment, relocation, resources and community support. It also provides space to ask questions and to get involved in Polls and feedback sessions.

c. The Events area contains two open access groups and a private members calendar, which hold various community activities and events, and training and support courses .

d. **Members' Area.** The Members' Area provides a Service Person and their friends/relatives membership to a password protected area where they can access ship/unit specific discussion forums. The site is moderated by trained personnel, who monitor content to ensure breaches of security are prevented, whilst also responding to queries or concerns within the online Service Community ensuring that the service is utilised appropriately. This also allows certain updates that cannot be open to all from the MOD and other stakeholders to be shared.

e. **Units.** Units, especially when deploying, must establish and regularly maintain a unit on-line community in partnership with RN FPS to communicate effectively with their families Annex 24G details guidance on establishing and maintaining an on-line community.

[2] navypeople-psrnfpsinfo@mod.gov.uk

2437. Short Term Family Accommodation (STFA)

a. In the base port areas and at some units a limited number of Service Family Accommodation properties are set aside for use as temporary self-catering accommodation, primarily for welfare reasons. The scheme is aimed at enabling Service personnel to utilise their facilities for both themselves and visiting friends or family members, with priority always being given to welfare/compassionate cases. Whilst use of the facilities will incur a cost to the Service Person, which is in excess of standard SFA rates, it will be less than that of privately rented accommodation. Users are liable for damages incurred and other local occupancy rules may apply, such as non-access for pets. For further information, personnel are advised to contact their local RN FPS Information Support or RN FPS Office https://forum.royalnavy.mod.uk/topics/accommodation-and-facilities/short-term-accommodation/.

b. Specialist Welfare staff may seek the utilisation of STFA for welfare/ compassionate cases if no suitable surplus SFA is available (in accordance with JSP 464 Volume 1, Part 2, Chapter 2, Annex C Serial 6 and Annex D Serial 5). Where specialist welfare staff apply for the use of STFA for welfare/compassionate cases, those responsible for the administration of STFA should allocate suitable accommodation where it is available, i.e. it is vacant or being used for lower priority or non-welfare reasons. In all cases the principles set out below will apply:

(1) Any information associated with the application to use STFA will be in accordance with the RN FPS code of confidentiality (see Para 2413).

(2) Following any initial approach, welfare/compassionate case applications will be confirmed in writing.

(3) Those responsible for the administration of STFA will provide written reasons in cases where no STFA is deemed to be available, confirming that there are no vacancies and/or accommodation is not being used for lower priority or non-welfare reasons.

(4) Where there are local criteria for the welfare use of STFA, these will apply where they adhere to these principles, however all applications will be dealt with on a case-by-case basis.

(5) The use of STFA will generally be in accordance with the SFA eligibility criteria set out by JSP 464, however in the case of welfare/compassionate cases a more flexible approach will apply based on the circumstances of each case.

2438. Welfare Funding and Support to the Community

Welfare is provided through a combination of public (core) and non-public (non-core) sources as well as (in the UK) Local Authority provision. Welfare support is separately delivered by a mixture of Service and civilian personnel and organisations. Information on supporting organisations may be found at Section 8 of this Chapter. Other details are contained within JSP 770 Chapter 2, which should be read in conjunction with JSPs 462 and 315 as well as single-Service regulations pertaining to Service Non-public Funds (BRd 18).

a. **Community Funding.** Funding from the Family Welfare Grant (FWG) is used to support families of RN personnel on qualifying deployments, which includes a programme of FWG events independent of deployed units. The respective Units will normally instigate and lead homecomings and other similar events alongside RN FPS staff however, the majority of FWG funding is primarily for events taking place before and during a period of deployment.

b. Building on existing policy, the RNTM 01-056-24 expands on the FWG eligibility and how it works in practice, providing examples of acceptable and unacceptable FWG spending. RN FPS holds the FWG budget however, NAVY PEOPLE-OPS DWP FIN SO3 manages it in practice. A portion of the FWG is ring-fenced for the RN FPS Community Support Fund (CSF), in line with existing policy and financial processes to ensure compliance with Navy Command policy and Corporate Governance. The aim of the CSF is to further support community development work and family activities in between deployment periods. Hd RN FPS provides a monthly report to Hd People Support on both FWG and CSF spend. For FWG / CSF budget requests, please contact:
NAVY PEOPLE-OPS DWP FIN SO3, NAVY PEOPLE-PS RN FPS HQ CL or NAVY PEOPLE-PS RN FPS Hd.

2439. Use of the Defence Estate

a. **Encroachment.** A number of welfare activities that are non-publicly funded operate from public buildings and, therefore, constitute an encroachment. Further guidance on encroachments can be found in JSP 850.

b. **Mixing of Public and Non-Public Funding on the Defence Estate.** Both government accounting regulations and JSP 462 make it clear that the MOD has no delegated powers to incur expenditure of a novel or contentious nature without the prior approval of HM Treasury.

2440. Secondary Duties - ‘Stand Behind’ Policy

Any Service Person engaged, as part of their duties, in Service non-public funds activities in support of unit welfare obligations, will be acting in the course of their employment with MOD or the Armed Forces. As such the MOD is vicariously liable for an individual’s actions in the pursuance of their duty. It is essential that personnel read and fully understand the latest DINs (currently 2025DIN03-007 and 2025DIN03-007) that outline this policy.

SECTION 6

CASUALTY SUPPORT

2441. Casualty Policy

Casualty policy, reporting and procedures are fully documented in JSP 751 Volume 1 (Management of the Casualty). The Royal Navy NOTICAS Directive is given at Annex 24H.

2442. Visiting Officers

The role and responsibilities of the Visiting Officer (VO) are detailed in JSP 751 Volume 2 Chapter 5 Section 5. In the Royal Navy, the VO role is fulfilled by trained RN FPS staff.

2443. Casualty Visiting Officers

At times of high operational tempo or in a mass casualty scenario a cadre of Casualty Visiting Officers (CVO) will be trained and supported to undertake the VO role and will usually deal with cases that present as less serious or complex. CVOs are primarily drawn from shore establishments, reserve units and rear parties.

2444. Visits by Relatives and Friends to Sick and Injured Personnel in Hospital

Arrangements for visits by relative and friends, including Dangerously Ill Forwarding of Relatives (DILFOR), are detailed in JSP 751 Volume 1 Part 1 Chapter 6. 2009DIN01-095 outlines the accommodation available for family members of Service patients at the Royal Centre for Defence Medicine (RCDM) in Birmingham.

2445. Casualty and Hospital Welfare Support

Primary Welfare support of patients remains the responsibility of the unit. Where there are complex welfare needs, specialist welfare support may be engaged. Serious and complex cases may have a Visiting Officer assigned and guidance of the management of the patient group can be found in JSP 751.

2446. Welfare Assessment

A Welfare Assessment may be undertaken at any time following admission and automatically after being admitted for seven days if an in-patient is considered to have additional needs beyond those of basic primary welfare. Welfare Assessments are to be undertaken by specialist welfare services, and a Welfare Co-ordinator will be appointed.

2447. Welfare Co-ordinator

The Welfare Co-ordinator will be appointed to manage the assessed welfare needs of the patient group and is usually part of the chain of command e.g. Recovery Cell staff. If the welfare needs are complex or require specialist input, a worker from RN FPS can be appointed.

SECTION 7

DECEASED PERSONNEL

2448. Management of the Deceased

JSP 751 Volume 2 (Management of the Deceased) covers the additional procedures to be adopted when death occurs in-service.

2449. Deaths in Ships, Units and Establishments

Initial action to be taken by non-police personnel on discovering an incident involving a death or where death is likely is contained in Annex 24E.

2450. Funeral Officers

a. If a Service Person dies, it is MOD policy to arrange a funeral at public expense or provide funding towards the cost of a private funeral, dependent upon the wishes of the Next of Kin (NoK).

b. Within the Royal Navy, Funeral Officers (FO) are appointed to work closely alongside the NoK, via the VO, to make arrangements for the funeral. FOs are appointed by the Royal Navy Casualty Cell (RNCC) and are drawn from a pool of trained and available personnel from the Naval Bases, larger shore establishments and RM units. FOs should be of CPO/CSgt rank or higher.

c. The FO role requires application of sensitivity as it can be an emotionally charged process. To assist with selection and appointment of FOs, and to avoid potential for being overwhelmed, the following criteria should be taken into account:

(1) Has the FO experienced a recent bereavement?

(2) Does the FO have a close family member or friend with a terminal or life-threatening illness?

(3) Has the FO been involved in a significant traumatic event e.g. serious road traffic incident, an incident involving death or near death, disaster relief?

(4) Does the FO have close family/significant other who is involved in hazardous duties?

d. FO training is co-ordinated and provided by the RNCC.

SECTION 8

ADVICE AND SUPPORT

2451. Welfare and Charitable Organisations

There are many organisations that may assist Royal Navy personnel and their families – these fall into three broad categories:

a. MOD Agencies and organisations funded by MOD (see Section 9);

b. Organisations not funded by MOD (see Section 10);

c. Charitable organisations (see Chapter 32).

2452. Defence Housing Assessments

a. In the first instance, housing applications and requests to transfer should be referred and supported, where necessary, by primary welfare providers, i.e. Divisional Officers/Regimental system.

b. If there is a clear requirement for Specialist Welfare input and support (e.g. the case is complex), RN FPS can be requested to undertake an assessment of need. If RN FPS's assessment concludes that there is a need, a supporting letter will be produced. This letter will give a clear explanation as to why the application is/is not supported by RN FPS, the anticipated effects on the family and the Service, and the associated risks if the application is not approved by Defence Infrastructure Organisation (DIO).

c. If an applicant(s) states a welfare need and requests specialist welfare intervention, they should be advised that before their request can be supported, a RN FPS case file needs to be opened.

SECTION 9

ADVICE AND SUPPORT: MOD AGENCIES AND ORGANISATIONS FUNDED BY MOD

2453. Veterans Welfare Service (VWS)

The VWS provides help and advice to veterans and is able to direct them to a range of government and charitable services. It also provides an integrated website and free helpline. The VWS can be contacted via the website on https://www.gov.uk/government/groups/veterans-welfare-service

2454. Hospital Welfare Service

The Hospital Welfare Service (HWS) is currently provided under contract to the Defence Medical Welfare Service (DMWS). The HWS assists commanders with the delivery of Primary Welfare to Service personnel in hospital and their families. https://www.gov.uk/support-for-veterans/defence-medical-welfare-service

2455. Medical Social Workers

The Defence Medical Rehabilitation Centre (DMRC) Stanford Hall maintains a team of qualified social workers in order to assist injured Service personnel and their families in coping with injuries and, where appropriate, in preparation for discharge on medical grounds. https://thednrc.org.uk/

2456. RN FPS Information Support

In addition to the RN FPS Information Support network, personnel and their families have full access to Army and RAF HIVEs in Army and RAF locations.

2457. Education Advisory Team (UK)

The Education Advisory Team (UK) (EAT(UK)) is part of Defence Children Services (DCS) and exists to provide information and support to Service families and eligible MOD civilians on all aspects of the education of their children in the UK. The most effective way to contact the EAT (UK) team is via email: RC-DCS-HQ-EAT@mod.gov.uk. https://www.gov.uk/government/groups/defence-children-services-dcs

2458. Defence Transition Services

Defence Transition Services helps service leavers and their families who face challenges as they leave the military and adjust to civilian life. Their services include transition to civilian housing, health and social care, finance, employment and education support. https://www.gov.uk/support-for-veterans/defence-transition-services

2459. Joining Forces CU

Joining Forces is a credit union service for the Armed Forces. It was launched to tackle problems faced by military personnel who may find themselves with limited access to financial services, leaving them a potential target for high-cost credit providers such as payday lenders and loan sharks. The service, backed by the MOD, makes saving simple and loans more affordable to the Armed Forces and its Veterans. Repayments come straight from your Armed Forces pay making savings and loans more manageable. The also off webinars and briefings. Credit Unions who are part of this can be found at www.joiningforcescu.co.uk.

SECTION 10

ADVICE AND SUPPORT: ORGANISATIONS NOT FUNDED BY MOD

2460. The Royal British Legion (RBL)

The RBL provides support to the Armed Forces Community who may need financial support. The RBL website is: https://www.britishlegion.org.uk/get-support/how-we-help.

2461. Seafarers' Advice and Information Line (SAIL)

SAIL is an advice service dedicated to all seafarers and their families across the UK. It is run by Greenwich Citizens Advice Bureau on behalf of the Seafarers Hospital Society and is funded in partnership with Seafarers UK and Greenwich Hospital. The website is sailine.org.uk.

2462. Citizen’s Advice Bureau (CAB)

The CAB service helps people resolve their legal, monetary and other problems by providing free information and advice from nearly 3,400 locations across the UK. The website is www.citizensadvice.org.uk.

2463. Relate

Relate offers a wide range of relationship counselling for couples, families and individuals and it supports people through all stages of their relationships and people can access the support individually or with others, face to face, on the phone or on the internet. The website is www.relate.org.uk.

2464. Samaritans

The Samaritans is a national charity with a network of autonomous local branches available 24 hours per day to provide confidential emotional support. The website is www.samaritans.org.

2465. Refuge

Refuge provides help and support to women and children escaping domestic violence. Refuge's network of safe houses provides emergency accommodation for women and children when they are most in need. The website is www.refuge.org.uk.

2466. Royal Navy and Royal Marines Widows’ Association (RNRMWA)

The RNRMWA is a group of volunteers which offers friendship, support and comfort to those bereaved when their spouse/recognised partner was serving in the RN/RM at the time of their death. The website is www.rnrmwidows.org.

2467. Stonewall

Stonewall works with a range of agencies which promote equality and justice for lesbian, gay, bisexual and transgender people in the wider community. The website is www.stonewall.org.uk.

2468. Royal Volunteer Service

The RVS is a large national welfare support organisation operating mainly on a volunteer basis, but with a dedicated full-time Service branch. This branch has a long-standing agreement and commitment to provide trained field officers to major Army units, particularly those with a training role or that are stationed overseas (including Northern Ireland resident units). The field officers, who are selected for their maturity and practical experience, are concerned mainly with single and unaccompanied soldiers. They seek to provide advice, guidance, sympathy and practical support in a variety of ways. Although their approach is essentially non-military, they are part of a unit's establishment and can undertake a variety of tasks on behalf of the CO, which may extend to the provision of small-scale clubs or leisure facilities. The RVS provides the service to the MOD under grant in aid terms. Nevertheless, RVS workers are not MOD employees and therefore have no authority to commit public funds. The website is www.royalvoluntaryservice.org.uk.

ANNEX 24A

WELFARE COMMITTEE AND SHIP'S WELFARE FUND

1. Introduction

This Annex applies to Royal Navy units; the word 'ratings' should be taken to apply also to Royal Marines Other Ranks borne in such units.

2. Object of the Welfare Committee

The object of the Welfare Committee in Royal Navy units is to provide a means for free discussion between officers and ratings of items of general welfare and general amenities within the ship or establishment that lie within the power of decision held by the Commanding Officer of their immediate administrative authority. Further details are as follows:

a. Subjects which the Welfare Committee may discuss include conditions in the ship, boat or establishment, messing arrangements, composition of meals, recreational activities, and any suggestions for the general welfare of the Ship's Company.

b. Subjects outside the scope of the Welfare Committee are general conditions of the Royal Navy (for example discipline, working hours, pay and allowances, leave scales, etc.) cooking and serving food from the galleys, and questions of primary welfare and amenities not directly connected with the particular ship, submarine or establishment.

c. The Welfare Committee is responsible for the administration of the Welfare Fund.

d. The Welfare Committee is to administer the affairs of the canteen if this is operated on the Service system. They are to investigate any questions and complaints that may arise about process and quality of canteen foods, weights and measures, and the general working of the canteen when it is operated by an outside contractor.

e. Nothing in this article is to interfere with or prejudice the right of an individual rating to put forward suggestions through their Divisional Officer or to affect the responsibility of the Divisional Officer for looking after the interests of those in the Division. See BRd 2 Chapter 18.

3. Formation of the Welfare Committee

a. A Welfare Committee is to be formed in each ship, submarine or establishment with a complement of 50 or more. A Squadron Welfare Committee is to be formed for ships with complements of less than 50.

b. Suitable arrangements are to be made by administrative authorities for other detached ships and small establishments with complements of less than 50.

4. Composition of the Welfare Committee

a. The committee is to consist of officers and ratings as laid down in BRd 9600 (Ships General Orders) Ch 7 Art 0702

b. Matters concerning the ship's canteen may be delegated to a small sub-committee appointed by the Welfare Committee from its members. In such circumstances, the sub-committee is to include the Logistics Officer, or their representative, and another officer.

c. The detailed composition of the Welfare Committee is left to the discretion of the Commanding Officer, subject to the following general principles:

(1) Representation should normally be by messes. Where this is not practicable, it should be by branches and or messes, or in shore establishments by any groups into which the establishment can most effectively be divided for the purpose of representation.

(2) Every rating borne must be able to vote for a representative, but no rating can vote for the representative of a division, mess branch or group other than their own.

5. Secretary of the Welfare Committee

A suitable rating is to be selected by the Welfare Committee to act as the secretary of the Welfare Committee. The secretary may be paid for their services from the Welfare Fund. The secretary is to be responsible to the Chair of the Welfare Committee for all aspects of their duties which include:

a. Collection of agenda items for Welfare Committee meetings.

b. Preparation of the agenda for approval by the Chair.

c. Circulation of the approved agenda to all representatives well before each meeting.

d. Recording the minutes of each meeting and exhibiting copies on noticeboards.

e. Maintaining records of any decision taken out of Committee. These should normally be kept for at least 2 years.

f. Maintaining records of all Welfare Committee meetings.

g. Taking actions as directed by the Chair of the Welfare Committee to implement decisions of the Committee.

6. Election of Representatives

a. When the composition of the Welfare Committee has been decided, a notice is to be exhibited showing the divisions, branches, messes or groups for each of which a representative is to be elected. Any rating in the Ship's Company or unit may then offer to stand for election to represent their division, branch, mess or group, and should submit their name to the nominated Returning Officer within 4 days of the notice appearing. It will also be open to each division, etc., to nominate a representative or representatives for election, subject to acceptance of nomination by the person concerned. The names of all candidates put forward are to be published on noticeboards for a period of 10 days before the date of the election, with any instruction that any candidate who has offered themselves or has been nominated for election but whose name is not on the list should immediately report to the nominated Returning Officer.

b. At close of nominations, if there is more than one candidate for a representative group then ballot papers are to be prepared for each of those voting groups showing the names of candidates for election. The ballot is to be run on the 'first past the post' principle, with the person receiving the most votes being elected. The paper must not be marked in such a way that the voter can afterwards be identified. For representative groups with only one nominated candidate, the nominated Returning Officer is to declare an uncontested election.

c. The ballot is to take place as required. The arrangements for recording the votes are to provide that the ballot is secret and takes place immediately after issue of the ballot paper and that no person can return more than one voting paper. Voting by proxy on behalf of personnel sick or on leave cannot be permitted.

d. The subsequent sorting and counting of votes is to be carried out in the presence of an officer and representative ratings. The results, including the names of any uncontested election, should be published on noticeboards as soon as possible thereafter.

e. Vacancies in the Committee are to be filled as they occur by means of by-elections. The tenure of a Welfare Committee representative should be no more than 24 months before being required to seek re-election. In seeking re-election, nominations are to be opened as detailed at para 6.a above. Commanding Officers may call for the re-election of the whole Committee if the conditions under which the ship is serving has or is planned to change, e.g. entering or leaving refit. In newly commissioned ships, however, a fresh ballot should be held after the ship has been three to six months in commission. A by-election will be necessary when any elected member of the Committee leaves the ship for any reason for more than 28 days (except on leave). Ratings sentenced to imprisonment or detention are to be removed from the Committee and their places filled by elections; those disrated for misconduct or reverted for unsuitability should be removed but not barred from re-election at the consequent by-election; those awarded a Service Supervision Order should be removed from the Committee and be ineligible for election until expiry of the Service Supervision Order.

f. In training establishments, to avoid the need for frequent by-elections, each class of trainees is to be represented by its class leader, provided that the courses are of sufficient duration; if not, the representation should be by suitable instructors.

g. A special organisation will be necessary for carrying out elections in ships with complements of less than 50, but it should as far as possible follow the principles laid down above and should be approved by the administrative authority.

7. Special Arrangements for Large Shore Establishments

At large shore establishments, including training establishments, where conditions differ considerably from those in other establishments and in ships, such arrangements for the composition of the Welfare Committee and the election of representatives are to be made as best suit the particular conditions. The arrangements should follow those for ships as far as possible and should not conflict with the general principles in these regulations without prior approval from Navy Command HQ.

8. Meetings of the Welfare Committee

a. Meetings of the Welfare Committee are to be held as required, but not less frequently than once every two months. Notice of subjects which it is proposed to raise at the next meeting should be given to the secretary, and an agenda should be circulated to committee members beforehand. Before circulation, the agenda must be approved by the Chair to ensure that the subjects for discussion are within the terms of reference of the Committee. Committee members will be expected to ascertain the views of the ratings they represent.

b. The Chair may arrange for the co-option of Divisional or other officers and ratings, when specific questions, in the discussion of which their experience would be of use, arise. The Canteen Manager may be invited to attend when the agenda includes items concerning the canteen.

c. No officers on the Committee are eligible to vote at the meetings.

d. Minutes of the meetings are to be kept for record, and copies are to be exhibited on noticeboards.

9. Welfare Fund

a. **Administration.** Administrative arrangements for the management of the Ship's Welfare Fund are contained in BRd 2 The King's Regulations for the Royal Navy Chapter 80 and BRd 18 Management and Accounting Instructions for Non-Public Funds.

b. **Trusteeship.**

(1) Trusteeship of the Welfare Fund of the ship, submarine or establishment rests with the Commanding Officer, who has a duty to veto any proposed expenditure which seems to them subversive of discipline, contrary to the law relating to charities, or otherwise improper. The circumstances in which such a veto is exercised are to be reported by the Commanding Officer to their administrative authority.

(2) The Commanding Officer is to pay due regard to the proportion of the Ship's Company who are able to take part in any particular form of recreation that may be the subject of assistance from the fund. In all other respects, subject only to the responsibilities of the Commanding Officer as trustee, the Welfare Committee is to have full discretion as regards expenditure.

(3) In judging whether disbursements are a proper charge to the fund it should be noted that, although the word 'efficiency' has in the context of Service administration acquired a limited meaning, in the charitable context it should be interpreted in the widest sense and taken to mean efficiency of the Service as an entity. It thus embraces measures to maintain or improve morale of members of the Royal Navy.

c. **Audit.** The accounts of the ship's Welfare Fund are to be kept and audited in accordance with the instructions in BRd 2 The King's Regulations for the Royal Navy Chapter 80.

d. **Disposal of the Fund on the Loss of Ship/Boat.** On the total loss of a ship/submarine, any balance in the ship's Welfare Fund is to be transferred to the Royal Navy and Royal Marines Charity.

ANNEX 24B

N1 FORUMS[1] AND UNIT CASE CONFERENCES WITHIN THE ROYAL NAVY

References:

A. BRd 439 Chaplain's Handbook.
B. BRd 1991 Instructions for the Royal Naval Medical Service.
C. RN FPS Confidentiality Code (see Para 2413).

1. Introduction

a. This annex provides direction on the implementation across all Commands of the N1 Forum (N1F) and Unit Case Conferences (UCC), which are subordinate to Case Conferences held by the Recovery and Resilience Margins HQ (RRM HQ) and the Unit Carers Conferences held by Royal Navy Family and People Support (RN FPS), yet should be considered mutually supportive.

b. It also provides guidance and standardisation to Commands for the conduct of N1F and UCC. The N1F and UCC are formal settings adhering to confidentiality practices, within which the agencies supporting the Executive organisation (RN FPS, Med, Chaplaincy, etc.) are brought together by the Executive, in order to assist the Divisional and Regimental System (Divisional Officer (DO) and Troop Commander (TC)), but primarily to support our Service Personnel (SP) and families.

2. Background

a. N1F and UCC already function across the RN providing support from Phase 1 throughout a SPs career. The agencies supporting the Executive organisation enable the coordination of appropriate care and support, ensuring it is delivered at the right time, when a SP or their family needs help. The best interests of the individual, their family and the Service are to be considered in order to maximise Operational Outputs.

b. The N1F is a formal setting for the Command, Divisional and Regimental Staff to discuss within a forum and with other Caring Professionals, the SP and families. Discussing matters that may be causing concern, placing personnel at risk to themselves or others, recognising symptoms and addressing matters before the need to escalate to other agencies, requiring the removal of the individual from their place of work. General concerns regarding wellbeing that may have been highlighted to the Command may also be discussed. The N1F, may, with the guidance of RRM HQ and RN FPS (Professional Agencies (PA)), wish to add the individual to the Risk Register (RR) or Vulnerable Risk Management Information System (VRMIS) where utilised.

[1] Although “Fora” is the grammatically correct plural of “Forum”, the more readable and widely understood “Forums” is accepted throughout this Annex.

c. The UCC is a formal setting which may be requested at any time by the Command, the DO, TC or any concerned party. It is chaired by the DO or TC with the Executive (Executive Officer (XO), Executive Warrant Officer (EWO)/Base Warrant Officer (BWO)/Coxswain (COXN) or Regimental Sergeant Major (RSM)) assistance and brings together professionals that may support and assist the SP, their family and the DO/TC. If the Executive deem any SP to be at risk, this individual should be referred to the appropriate PA where consultation may take place, with the possible inclusion on the RR.

3. Organisation

a. The N1F and UCC are administered by the XO, EWO, BWO, COXN, RSM and SO2/3 Logs on behalf of the Commanding Officer (CO). These individuals are to ensure that N1F are held regularly, dependant on the size, structure and function of the group or element, but no less than once per month and no greater than weekly, with UCCs being held as required, with the appropriate individuals in support listed below (Not all individuals may be available or required, particularly in ships and submarines):

(1) XO/2i/c.

(2) EWO/BWO/COXN/RSM.

(3) DO/TC.

(4) Departmental Co-ordinator/Troop Sergeant (If required for employment restrictions, etc).

(5) Legal.

(6) Service Police.

(7) Medical[2].

(8) Chaplaincy[3].

(9) Royal Navy Family & People Support (RN FPS).

(10) Any other supporting agency thought necessary (e.g. Career Manager).

b. Within Naval Bases (NB), RM Units and large Shore Establishments (SE) the Executive may wish to delegate the N1F and UCC to Heads of Department (HOD), Training Groups (TG) or Lodger Units (LU), with an approved nominated Officer of SO2 or above to chair the N1F or UCC when required, within each TG/LU, drawing upon the resource of departments as required. The CO and Executive are to be made fully aware and, if necessary, verbally briefed on any SP required to be discussed at an Executive N1F or UCC and immediately upon recommendation to be included on the RR/VRMIS.

[2] BRd 1991 Instructions for the Royal Naval Medical Service.
[3] BRd 439 Chaplain's Handbook.

c. Smaller Shore Establishments, Ships, Submarines and Units should manage centrally N1F and UCC within the Executive organisation. External professionals may be included, if possible, and the use of technology to ensure the most complete picture is compiled and the most comprehensive support is made available.

d. NBs and large SEs will convene an Executive N1F to discuss individuals or issues raised at the individual Group N1Fs that require Command attention (Phase 1 and 2[4] Elements will report directly to the CO). The purpose of the Executive N1F is to raise awareness of, and where possible resolve issues that cannot be addressed at TG/LU level. This forum will be attended as directed by the Executive and the TGs/LUs Divisional Staff.

e. Personnel Support Groups, Recovery Troops and RNRC Haslar exceptionally hold their own N1F and UCC given the numbers of personnel within their organisations ensuring concerns are shared with the Executive and included on VRMIS as required. Where necessary cases may be discussed at the Executive N1F.

f. Attendance to support a N1F or CC is to be given the highest priority by all concerned.

4. Confidentiality[5] [6] [7]

Appropriate confidentiality practices must be observed and guidance in support of the Executive and DO/TC should be briefed at each N1F and UCC.

5. N1 Register[8]

a. The N1 Register is a detailed diary of events, actions taken, recommendations and the category of risk, which may inform the RR/VRMIS. The N1F E-register is an Official Sensitive – Personal document and is to be maintained iaw the Data Protection Act 2018. Information from the N1 Register is only to be disclosed to those personnel on a ‘need to know Basis' determined at the N1 monthly brief with the CO or to those desired by the CO in the course of their duties. The N1 Register is held and maintained by SO Logs and briefed regularly to the Command.

b. The N1 Register will be reviewed at the N1F and any actions arising briefed for action by the DO and/or the individual. No cases will be removed from the register without the Command considering any new information pertinent to the case. Careful consideration must be made on the requirements to inform other units if it is deemed necessary for any individual to remain on the RR/VRMIS or within the N1F construct, when assigned.

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[4] JSP 822 Part 1(Defence Direction and Guidance for Training and Education)
[5] JSP 950 Part 1 (Medical Policy) Defence Medical Services Caldicott Policy, Lft 1-2-15 (V1.2) Sep 16
[6] BRd 3(1), Naval Personnel Management, Ch 24 Welfare, Para 2413 Royal Navy and Family People Support Confidentiality Code
[7] RNGC1 02/104 (RN FPS Confidentiality Code)
[8] BRd 3(1), Naval Personnel Management, Chapter 24, Appendix 1 to Annex 24C (Management of Care Arrangements for Service Personnel 'At Risk' and Sensitive Case Reaction Team (SCART))

c. The N1 Register has two categories, A and B. These provide guidance on the delivery of Care and Welfare (C&W) (Executive, Medical, and Chaplaincy, etc.) and the level of support required:

(1) **Category A Cases.** Individuals who are considered highly vulnerable and are likely to require close and frequent supervision.

(2) **Category B Cases.** Individuals considered to be at an increased level of vulnerability and are likely to require routine and regular access to sources of assistance outside the Divisional system.

6. Management of Meetings

a. The Executive or TG/LU representative will be responsible for the creation of an agenda, records and must also provide actions (a plan) for each DO/TC regarding everyone discussed. UCC will be administered by the DO ensuring outcomes are recorded and comply with paras 4 and 5. The format may be created locally to suit the needs of the user; however, the Executive may wish to produce their preferred agenda.

b. The agenda may include, but is not limited to:

(1) Introduction and Apologies.

(2) Actions Review.

(3) Service Discipline (to include Minor Administrative Action).

(4) Civil Offences.

(5) Service Complaints/Representations.

(6) Warnings.

(7) Medical (Wounded, Injured and Sick (WIS), medically non-deployable, RNMBOS, Joint Medical Employment Standards).

(8) Recovery Plan.

(9) Review Risk Register/VRMIS.

(10) Review Actions.

7. Conclusion

The N1F and UCC construct provides an opportunity to exchange information about personnel assessed to be vulnerable, in a confidential environment, and by so doing so determines a course of action to reduce the risk to the SP or others and provides the DO/TC with the best means to assist individuals within their division. It is an important tool to assist in the delivery of support to our people as well as the maintenance of morale and discipline. It does not seek to replace the Divisional System, rather it augments it.

ANNEX 24C

N1 RISK REGISTERS – VULNERABLE RISK MANAGEMENT INFORMATION SYSTEM (VRMIS)

References:

A. Army General and Administrative Instructions Volume 3, Chapter 110 – Identification and Management of Vulnerable Individuals: AGAI 110[1]
B. VRM / VRMIS page of the Army Digital Services (ADS) Catalogue[2].

1. Introduction

a. The N1 Register is a tool to support N1 forums (sometimes referred to as Carer's forums) and Unit Case Conferences. VRMIS is a system introduced by the British Army and now adopted by the Royal Navy to support vulnerable people risk management, created with the aim of minimising the number of incidents of suicide and self-harm and provide guidance for Commanders and the CoC to:

(1) Assist them to identify personnel at risk of Suicide and Self-Harm behaviours.

(2) Signpost appropriate responses to actively manage and support individuals at risk.

b. Whilst broader RN policy regarding Vulnerability Risk Management (VRM) is under continuing review, the rollout of VRMIS minimises risk in losing information, or Commanders being unaware of vulnerable people assigned to their units. VRMIS supports the Commander and Executive Team to identify and review their vulnerable personnel or dependencies and assign lead officers or case workers. Importantly, it positively controls the passage of information between units if a vulnerable person is assigned. From a unit perspective, trends can be observed, which may warrant external support.

c. The VRM process is a leadership function and command led activity which requires a multi-agency approach to identify, manage, and support SP who are considered to be vulnerable and therefore potentially at risk of self-harm and/or suicidal behaviours. Each record on the Unit VRM Register held on VRMIS forms the case history of the actions taken by the CoC and those parties supporting the individual to manage, support and care for them whilst they are considered to be at risk. The full case history contained within the Care Action Plan (CAP) will be provided to the Coroner in the event of a death and to the President of any Service Inquiry that is convened.

[1] https://modgovuk.sharepoint.com/sites/IntranetArmy/Shared%20Documents/AGAI_110.pdf
[2] https://remedy19.ahe.r.mil.uk/dwp/app/#/catalog

d. VRMIS is a tri-service closed application, and access is strictly restricted to designated users (via their MODNET PUID), with only the Commanding Officer and the Unit VRM Lead having read-only access to all individuals' records within the unit because of the roles that they occupy. All personal, welfare and medical data must be protected in accordance with the Data Protection Act 2018 (DPA 18) and the General Data Protection Regulations (GDPR). Health and Social Care professionals should refer to the Caldicott principles and their own respective professional regulations around the duty to share information and/or breaching of confidentiality. The Data Protection Impact Assessment (DPIA) has been completed by the RNTM Sponsor with risk held at 2* level by Director People and Training.

e. Headquarters Command Force (HQCF) is responsible for ensuring that all RM and RMR Units have access to and are aware of their responsibility to use VRMIS for managing individuals assessed at risk. The Recovery and Resilience Headquarters have interim responsibility for all RN and RNR Units having access.

f. The VRMIS system has been successfully adopted across all RM Cdo units, the Royal Marines Band Service (RMBS), Royal Marines Reserve (RMR), Naval Base Personnel Support Groups (PSGs) and the Royal Navy Recovery Centre (RNRC) Hasler. It has been subjected to rigorous stress testing, both in terms of its functionality and its role in supporting vulnerable individuals and been pivotal in after-action reviews when individuals were at risk of self-harm. Moreover, it has played an important part in proactive intervention, allowing the Chain of Command to step-in before self-induced or system-induced pressure becomes a contributing factor.

2. Guidance for Chain of Command.

a. In determining who may be deemed vulnerable and at risk, there are many factors out-with diagnosis of psychiatric illness to consider, including:

(1) A history of self-harm.

(2) Relationship problems / breakdown / Family Issues / Toxic Relationships.

(3) Significant Loss.

(4) Substance Misuse including failed CDT.

(5) Alcohol misuse.

(6) Loneliness or isolation.

(7) Current pending legal or disciplinary action.

(8) Work related problems (stress, excessive workload, under manning/gapping).

(9) Investigations in relation to sexual offences.

(10) Financial problems.

(11) Transition (retirement, discharge etc).

b. It may not be the risk factor that is identifiable or identified, but a behavioural aspect or change as a result of that risk factor. Just because an individual has not been diagnosed with a psychiatric illness is not a reason in itself to exclude them from management under the VRM process.

c. Everyone has a responsibility to report to their immediate CoC if they have concerns of an individual that may be at risk of Suicide and Self-Harm behaviours or is vulnerable. Where ranks are highlighted the CoC should immediately convene a Case Conference (CC). The CC should consider appropriate attendees, being mindful of 'need to know' aspect of Caldicott, which may include the following:

(1) CO or delegated representative.

(2) Unit 2I/C/XO/CSM/SSM.

(3) RSM/EWO/Cox'n.

(4) Adjutant/Discipline Advisor.

(5) Medical Officer/Medical Branch Rating/DCMH practitioner/Mental Health nurse.

(6) Unit Padre/Chaplain.

3. Roles and Responsibilities. There are **three** defined User roles within VRMIS:

a. **The Commanding Officer.** The risk of self-harm or suicide behaviours is owned by the Chain of Command. As such CO's (or equivalent) are responsible for ensuring that BRd 3(1) Chap 24 is complied with, and that the VRM process (including maintaining the open CAP on the VRMIS system) is applied correctly within their unit. COs are also responsible for ensuring that a culture of trust, confidential disclosure, and non-stigmatisation of VRM issues is engendered throughout their unit to enable the effective identification and management of service personnel who may be vulnerable and therefore potentially a risk of self-harm or suicidal behaviours.

b. **The Unit VRM Lead.** Has overall responsibility for the maintenance and management of the Unit VRM process and Unit VRM Register on a day-to-day basis directly on behalf on the CO. They must be appropriately trained for the Unit VRM Lead role which should have been undertaken as part of their respective pre-employment training. They are also required to provide formal Level 1 assurance to the CO that the unit is complying with this RNTM and process and raise any concerns to the CO where there is non-compliance within their unit. The Unit Lead must ensure that CAP Leads are correctly trained on the management of a CAP and the use of VRMIS. Without being prescriptive, the VRM lead is likely to be the 1st Lieutenant, EWO, Cox'n, XO, G1 Advisor etc i.e. the role currently responsible for the N1/Carer's forum. The VRM lead will need to register for a VRM account by providing Army VRM lead with their PUID, role name and UIN (Army Pers-Health-HPW-VRMPol-SO2).

c. **The Care Assessment Plan (CAP) Lead.** The CAP Lead is normally someone in the individual's chain of Command and is responsible for creating, updating and maintaining the Care Assessment Plan on VRMIS. They should be at an appropriate level within the CoC and will usually be the Divisional Officer (DO) or Troop Commander (Tp Cdr). If the Tp Cdr or SNCO is not the CAP lead, they must be granted visibility to the CAP by the CAP lead to allow them to fulfil their legal duty of care responsibility, conduct the monthly formal review of the case, and be fully aware of the current situation of their subordinate and level of risk that they are holding.

4. Management of VRMIS Accounts. The Unit VRM Lead is primarily responsible for the granting access to, and management of, unit VRMIS accounts:

a. Unit VRM Leads receive their VRMIS access permissions from their predecessor who is responsible for transferring all open and closed cases held on the Unit VRM Register to their successor as part of their formal HO/TO.

b. There are limited occasions where the VRMIS Senior User (Army Pers-Health-HPW-VRMPol-SO2) will create Unit VRM Lead permissions: on the establishment of a new unit that requires VRMIS access, or, if the Unit VRM lead is unavailable due to being incapacitated and as a result is unable to transfer their permissions and cases linked to their PUID.

c. The Unit VRM Lead is also responsible for granting access to VRMIS for the CO and all CAP Leads on creation of the entry on VRMIS or by using the internal transfer function[3] or bulk transfer function[4] on VRMIS as personalities change.

d. The CAP lead is responsible for granting and ending Visibility access to the CAP.

e. The Unit VRM Lead must transfer their responsibilities and all cases to a nominated replacement during any periods of absence (such as Leave, Long Courses, Deployments etc). This is completed by initiating a "Bulk Transfer" of cases linked to their PUID (i.e. JonesB123) across to the nominated replacement which will create their VRM Lead permissions at the same time, who will transfer all cases back to the formal Unit VRM Lead on their return.

f. The Unit VRM Lead is also responsible for conducting a full handover of their role regarding the application of the VRM process within the unit and the Unit Register held on VRMIS to their successor and does this by using the Bulk transfer functionality in the VRMIS application which also creates their successors access permissions at the same time. The VRMIS process guide on handing over the Unit VRM Lead role and all cases on the Unit VRM Register, either temporarily or permanently on assignment, is located on the VRM page of the Army Digital Services (ADS) Catalogue.

[3] Where only one case needs to be transferred.

[4] Where there are multiple cases to transfer.

g. The Unit VRM Lead is also responsible for updating the CO and CAP leads on VRMIS as personalities change. Where multiple records need to be re-assigned as part of this process, this can be completed quickly and efficiently using the bulk transfer functionality in the VRMIS application, or for single cases this can be completed using the individual transfer function on the specific record. The VRM process guides on updating the CO and updating the CAP Lead are accessible via the VRM page of the Army Digital Services (ADS) Catalogue.

5. Access

a. VRMIS access is linked solely to an individual's MODNET PUID and not to their post or role within a Unit. VRMIS is accessible using the launch application button on the VRM Page of Reference A or using the following link: https://vrm.ahe.r.mil.uk/. Access is only available to those personnel directly involved in the management and support of an individual on the Unit VRM Register and for whom access by their Unit VRM Lead (or Care Action Plan (CAP) Lead in respect of visibility) has been granted. The VRM lead will need to register for a VRM account by providing Army VRM lead with their PUID, role name and UIN.

b. It is paramount that when an individual who has VRMIS permissions is assigned from their Unit, that they have their VRMIS access withdrawn immediately. This is the responsibility of the individual themselves who must log a call via the VRM page of the Army Digital Services (ADS) Catalogue, provide their PUID and request that their VRMIS access is removed. Prior to completing this request, they must ensure that the Unit VRM Lead has transferred all cases linked to their PUID and/or any open visibility has been ended by the respective CAP lead. Access to VRMIS will not be removed if there are cases still linked to their PUID. If the departed VRMIS user requires VRMIS access at their new unit, it can be created by their receiving Unit VRM Lead once they take on VRMIS responsibilities in their new role.

c. The respective CAP lead is responsible for granting and ending Visibility (read-only) access on a CAP. The Commanding Officer (CO) and Unit VRM Lead have automatic read-only access because of the positions they hold on VRMIS, so separate visibility does not need to be granted to them by the CAP Lead.

d. Any individual granted visibility will have read-only access to the record on VRMIS that their PUID is linked to. Normally those granted visibility will be in the SP's CoC or be someone who is involved in the management, care and support of the individual on the Unit VRM Register such as the Chaplain, MO, DCMH clinician or RN FPS caseworker and visibility can only be granted with the express permission of the individual on the VRM Register. The CAP Lead should consider giving attendees at the N1/Carer's forum/Case Conference access to VRM.

e. Where the CAP lead has been delegated, the new lead CAP lead must be granted visibility.

f. The following summarises the access permissions and who is responsible for granting them, and responsibilities of each of the roles laid down in Para 3 above which must be adhered to:

(1) **Commanding Officer.** As the owner of the risk, the CO has read only access of all VRM records held on VRMIS in their unit. Their access to VRMIS is created by the Unit VRM lead when they assume command (the Unit VRM Lead facilitates an internal transfer on VRMIS to move all open and closed cases from the outgoing CO to the Incoming CO creating their access at the same time) and when new cases are added to the Unit VRM register held on VRMIS. The CO must ensure that they have access to, and can access VRMIS, and be aware of all open cases held on their Unit VRM Register. The CO is also responsible for ensuring that they conduct a formal review of all open cases at the monthly N1 forum/CC details of which must be recorded in the CAP by the respective CAP Lead.

(2) **Unit VRM Lead.** The Unit VRM lead access is granted by the outgoing Unit VRM Lead as part of their formal HO/TO which must include the transfer of all open and closed cases from the departing Unit VRM Lead to the incoming Unit VRM Lead. The Unit VRM lead has the following responsibilities:

(a) Read only access to all Unit records held on VRMIS.

(b) Convening the N1/Carer's forum/MUCC and any subsequent ICC, including production of the Record of Decisions (RoDs) which must include attendance, details of the discussion and decisions made, a Summary of Risk Factors (SoRF) identified and agreed Actions and Measures for inclusion in the CAP once initiated.

(c) Where the decision was made to place someone onto the Unit VRM Register, the Unit VRM Lead must create the register entry on VRMIS, adding the identified risks (SoRF) from the CC as Tags as part of the entry process and assigning the CAP Lead permissions.

(d) Where the decision was made not to place SP onto the Unit VRM Register as this RNTM and guidance from Para 110.025f of AGAI 110, the Unit VRM Lead must still create an entry on VRMIS and use the "Initial Risk Conference Only" Tag, assign themselves as the CAP lead, initiate the CAP and record the meeting from the ICC as an Event, closing the CAP straight away (so that it can be referred to (and reopened) if the individual comes back onto the radar).

(e) Ensuring that all open cases are formally reviewed by the CO at the MUCC in accordance with BRd 3(1), Chap 24. This must include a review of any outstanding actions, current measures and actions, a review of risk factors along with an understanding of progress being made by the individual, along with any D&G provided by the CO.

(f) Managing unit VRMIS access and raising all internal transfers when required (this means updating personnel in VRMIS roles such as the CO and CAP Leads as personalities change).

(g) Raising External transfers (on the assignment of an Individual who has an OPEN or CLOSED case on the register). This formal transfer of an open case must only be actioned once a UCC has been held and the full details recorded in the CAP.

(h) Ensuring that all CAPs on the Unit VRM Register are up to date (including chasing any CAP leads to bring their records up to date as necessary). Out of date records (those that have not had a formal ICC or MUCC review entered into the CAP for more than 30 days) will appear in red text on the VRMIS front page.

(i) Handing over to an appropriate individual when absent on leave or duty (using the Bulk Transfer function to update the VRM lead on all records).

(j) Handing over the Unit VRM Register & VRMIS responsibilities to their successor in a timely manner and submitting a request via the VRM page of the Army Digital Services (ADS) Catalogue to end their VRMIS access.

(k) Providing assurance to the CO that the unit is fully compliant with both BRd 3(1) Chap 24 and this RNTM and the VRM process and that all cases are up to date on the Units VRM Register held on VRMIS.

(l) Ensuring that all CAP leads are aware of their role and responsibility in regard to the VRM process and use of VRMIS and if they have not completed learning in this area then provide an awareness briefing to them using the materials accessible on the VRM page of the Army Digital Services (ADS) Catalogue[5]. Ensure the VRMIS Awareness training competency is awarded when and to whom these briefings have been provided.

(3) **Care Action Plan (CAP) Lead.** The CAP Lead is responsible for the day-to-day management and engagement with the individual who is entered onto the Unit VRM Register along with those parties who are supporting the individual. **The CAP Lead, who is the only person who can initiate, edit, and close the CAP** has their access permissions granted by the Unit VRM Lead. Specifically, the CAP Lead is responsible for:

(a) Initiating the Care Action Plan (CAP) on VRMIS once the Unit VRM Lead has created the entry. The CAP lead must initiate the CAP in a timely manner, and throughout the time that the CAP is open maintain a chronological summary of events, actions, and measures on the CAP.

[5] https://remedy19.ahe.r.mil.uk/dwp/app/#/catalog

(b) Populating the Overview page of the CAP paying particular attention to ensuring that the summary of risk factors identified at the ICC are included.

(c) Recording the full details of the attendance, discussion and decisions made at the ICC as an Event in the CAP along with entry of the agreed Actions and Measures (this information will be provided to them by the Unit VRM Lead).

(d) Adding and removing Visibility (read-only access) on the CAP.

(e) Obtaining and recording a signature from the individual on both entry onto VRMIS and prior to CAP closure and recording the signature date in the Signature tab of the CAP and uploading the signature page into the documents section of the CAP.

Note. *An entry into VRMIS does* ***not*** *require explicit consent of the individual concerned, however a signature from the SP in the CAP is required to confirm the individual has been informed of said entry.*

(f) Obtaining authority to share information as necessary by obtaining a signature from the individual and recording this in the CAP.

(g) Recording all formal and informal reviews, interactions, and updates in respect of the SP on a CAP, including but not limited to details of changes to a SP's situation, engagement with any of the SP's family, any refusal by the SP to engage in the process along with what has been done to try to encourage engagement.

(h) Recording updates provided by the third parties who are supporting the individual as Events in the CAP, including uploading documents provided by these third parties.

(i) Adding new Tags to the CAP as new risks are identified and ensuring that both the summary of risk factors is updated on the Overview page of the CAP and an Event is created that provides full details of the new risk and any newly agreed Actions or Measures put in place to assist in mitigating this risk.

(j) Creating a Leave Plan with the individual at risk, or a contact and safety netting plan if the SP is sick at home or suspended from duty, and monitoring or contact is required during this time, ensuring that individual has a copy and that its creation is recorded as an Event in the CAP and a copy uploaded into the documents section of the CAP. Templates are available on the VRM page of the Army Digital Services (ADS) Catalogue.

(k) Recording details of any Safety Plan that has been created and ensuring that a copy is uploaded into the documents section of the CAP and reviewed as part of the formal monthly reviews. Templates for the creation of a Safety Plan are available via Staying Safe | from suicidal thoughts and on the VRM Page of the Army Digital Services (ADS) Catalogue.

(l) Ensuring that the CAP is up to date and that regular case management reviews with the individual are conducted and full details recorded as Events in the CAP along with and changes to the agreed Actions and Measures. This must include the details of the formal N1/Carers forum/MUCC in accordance with BRd (3) 1, Chap 24.

(m) Where an individual is leaving the service (regardless of the reason for leaving) and has an open CAP that an assessment of ongoing needs is completed. The SP name and service number should be sent to Army Pers-Health-HPW-VRMPol-SO2 for the account to be closed. Defence Transition Services (DTS) and Veteran Welfare Support (VWS) provide ongoing support, guidance and information to service leavers and their families on issues that will endure beyond discharge. DTS and VWS support is available irrespective of the reason for discharge and is available to regular, reservists and their families. Referrals into DTS/VWS are made using the Defence Transition Referral Protocol (DTRP) detailed in JSP100 part 227. This can be made on behalf of the SP or family member by any responsible tri-service military authority, or by the individual SP or family themselves through self-referral. RM ranks can also be referred to the RMA Local Case worker upon being identified as a vulnerable Service Leaver.

(n) Recording full details of all formal risk conferences (N1/Carers forum/UCC) that take place. This must include details of who attended, the discussion that took place, review of the SoRF, review of outstanding actions and open measures and any decisions that were made.

(o) Attending and recording the full details of any HO/TO CC that takes place when an individual with an open entry on the Unit VRM register is assigned in accordance with this RNTM. The requirement for a HO/TO CC to take place also applies to those personnel with an open CAP who are moving to a Workforce Resilience and Training Margin or Service Custody.

(p) Ensuring that they conduct a handover of the CAP with their CAP Lead successor and that this is recorded in the CAP.

(q) Ensuring all documents pertaining to the case are uploaded into the documents section of the CAP on VRMIS and that a corresponding event is created that provides details of the document that has been uploaded.

(r) Once a decision has been made to remove someone from a Unit's VRM Register, record full details of the N1/Carer's forum/CC including the COs decision regarding removal, obtain a signature from the individual and upload this into the CAP along with any other documents, then close the CAP.

(s) Following a death of an individual who has an open entry on VRMIS, downloading the CAP and any documents held on the documents section of the CAP and emailing it to the Unit VRM lead to allow them to follow the actions laid down in BRd 3(1) Chap 24 Annex 24E.

6. Care Action Plan (CAP)

a. The CAP is a chronological version of events that demonstrate how the individual on the VRM Register is being managed and supported by the CoC/Unit. It will be given to the Coroner if the individual dies as part of the evidence pack to allow the Coroner to view how the unit have managed and supported the individual. It can also be called for as evidence in any Service Complaint or provided as a result of a Subject Access Request (SAR), Service Inquiry or Legal Proceedings. The Unit VRM Lead and CAP lead **MUST NOT** be the same person.

b. Central to the development of the Care Assessment Plan (CAP) is the requirement to focus on the development of protective measures which should try to address the underlying causes. It is likely to involve: a combination of physical measures (such as limiting access to weapons); engagement of professional help (such as Specialist Welfare or Medical) ,and maximising other protective factors (e.g. instigate a "buddy-buddy system"). The construction of the CAP and delivery of the management and care to an individual at risk **should have the engagement and consent of the individual** and may have multi-agency input, for example: medical, Royal Navy Family People Support (RN FPS), Chaplain etc. No two cases are the same.

7. Access to the VRM page of the ADS Catalogue. The VRM page held on the ADS Catalogue contains useful information linked to the VRM process and VRMIS. This page can be accessed directly via the Army Digital Services (ADS) Catalogue or via the Help and Support button in VRMIS. If individuals are unable to access the ADS Catalogue, then they must complete and submit the form at the following link: ADS Service Desk Incident Reporting Form (office.com)[6] so that their access can be enabled.

[6]https://forms.office.com/Pages/ResponsePage.aspx?id=7WB3vlNZS0iuldChbfoJ5X-Afu3wZlxOlxB_4uYzR_lUNUE5NVFQTFpUS1VXOUtUSU02VVRXU0wzUC4u

8. Application Issues. All individuals with any VRMIS application or access issues must raise a call in the first instance via the VRM /VRMIS page of the Army Digital Services (ADS) Catalogue by selecting the **"**Report an Incident" button then completing the "Report an issue with VRM" online form. This process should also be used in the following circumstances: when requesting that a User's VRMIS access if ended (e.g. when they are no longer in the Unit), updating VRMIS account role names where this has changed from when first created, reopening closed records on VRMIS, requesting that text entered in error on an open CAP be removed, removal of any documents uploaded in error, or removal of any Tags added in error.

9. User Guides and Templates. User Guides for the VRMIS application and templates such as the HO/TO risk conference agenda, Leave Plan, Safety Plan etc are available on the VRM page of the Army Digital Services (ADS) Catalogue.

10. VRMIS Awareness and CAP Lead Training. Unit VRM Leads are responsible for awareness and training for CAP Leads. Delivery of material on the VRM Process, including the creation and maintenance of a CAP and the use of VRMIS is delivered by HQCF WO Discipline Adviser. Bi-monthly training sessions via Teams are also available – to be added to a session, email NAVY PEOPLE-PS RRM SO1. Unit VRM Leads are responsible for ensuring that all CAP leads are aware of their role and responsibility in regard to the VRM process and use of VRMIS. If CAP Leads have not received briefings at their respective pre-employment course the Unit VRM Lead must provide awareness briefings to them using the materials accessible on the VRM page of the Army Digital Services (ADS) Catalogue. Additional CAP lead and VRMIS training can also be provided by the AGAI 110 policy lead / Senior VRMIS user to units when capacity allows (and where a VRMIS Awareness Competence on JPA will be awarded – Welfare│ VRMIS Awareness│Joint).

ANNEX 24D

DELIBERATE SELF HARM (DSH) AND SUICIDE

1. Background

Deliberate Self Harm is a non-fatal act of intentional self-harm irrespective of the apparent purpose. The Service has a direct duty of care to correctly manage personnel who present with actual or threatened DSH, and the considerable stigma associated with these actions must be overcome, although this can be challenging in areas with a low tolerance for such actions. This Annex contains guidance for those to whom these cases present which include the Executive, Medical Service, Chaplaincy and RN FPS. The aims of this guidance are as follows:

a. To ensure that individuals presenting with DSH receive the appropriate management of their physical and mental health, in line with best practice and National Institute of Clinical Excellence guidelines.

b. To maintain the good order, morale and operational effectiveness of the unit and, ultimately, the Service.

c. To ensure that DSH and suicide cases are appropriately investigated, recorded and acted upon, and lessons learned for the future.

2. Introduction

a. Both actual and threatened self-harm are typically a communication of distress and need. Individuals can, however, have serious suicidal intent. The identification and management of individuals who commit acts of DSH is therefore critical, and these individuals are significantly more likely to commit suicide within the following year than the general population. Acts of DSH generally fall within one the following categories:

(1) **To Communicate a State of Distress to Others.** Adult life can at times cause heightened psychological distress; common causes include difficulties with relationships, family or employment. It is normal to want to communicate this with others, however the mechanism through which some do this is either actual or threatened DSH.

(2) **Physical Release for Emotional Distress or Tension.** DSH may be a mechanism of release from distress for an individual. This can be a learned behaviour and is usually associated with a degree of personality dysfunction. Some of these acts of DSH will be concealed and not come to light through routine interactions, for example through superficial cutting on skin usually covered by uniform. This pattern of DSH is less common in the RN.

(3) **To Complete Suicide.** Acts presenting as DSH may have been serious attempts to complete suicide, which may have been either unsuccessful, or the act was thwarted.

(4) **To Influence People or Events to Avert Undesired Outcomes.** At times, DSH, and particularly threats of future DSH, can be used to influence events and alter an outcome for the individual. This functions by raising the concern and anxiety in someone who has power and influence within a situation. This can be commonly seen with relationship and family discord. In the RN, threats of DSH may be used to avert unwanted Service obligations which the individual feels unable to tolerate emotionally, and these presentations can be particularly challenging to manage.

b. Common mechanisms of DSH include skin laceration and poisoning by overdosing on medication. More violent methods such as hanging and jumping from height are more significant in determining suicidal intent but are less frequent presentations.

c. It is important to note that DSH can occur in the presence or absence of a distinct mental illness.

d. Individuals who present with DSH should be treated with the same care, respect and privacy as any patient. Those involved in the management should take full account of the likely distress associated with such presentations. It is acknowledged that presentations of DSH can be challenging to manage, particularly in the operational environment, and a tolerant and compassionate attitude may be required to overcome this.

3. Initial Management Following DSH Event

a. When an act of DSH occurs, medical assistance should be sought immediately. The need may be readily apparent, but in cases of self-poisoning the individual may seem completely well but have ingested a potentially life-threatening substance. Depending on circumstance this may be through the Medical Officer/Medical Branch Rating, or Duty First Aider as appropriate. Civil emergency services may be required, and this should not be delayed if it is apparent that an individual's life is in danger.

b. After any immediate physical health needs have been met, the Medical Officer/Medical Branch Rating will need to complete a full mental health risk assessment, to inform the ongoing management. Appendix 1 to this Annex details the requirements for medical professionals and provides a comprehensive guide to the risk assessment process.

c. Prior to, and during, a mental health assessment, it will be necessary to manage the individual in a safe environment. The nature of a safe environment can range from the supervision of an appropriately responsible person, through to containment under constant supervision. Typically, this will be in the Medical Centre or accommodation area, however the context may further dictate this. Detention in custody may ultimately be deemed necessary but should be fully justified in the best interests of the individual, and only on the authority of the Commanding Officer/Duty Commanding Officer. The necessity to contain an individual in these circumstances would be in the interests of the individual's own health or safety, or that of others, when the following risks may be present:

(1) A risk of harm to themselves.

(2) A risk of harm to others.

(3) When there is a risk of deterioration in mental health.

d. Any level of supervision should be maintained for the minimum amount of time necessary to permit the mental health assessment and should be conducted in an environment and atmosphere of due care and compassion.

e. If it is deemed that an ongoing level of protection is necessary in the interest of the individual's health or safety, or that of others, then the appropriate mechanism will be determined by location. Appendix 1 details guidance to medical professionals on how to access specialist advice and services.

f. In all cases of DSH, the Notification of a Casualty (NOTICAS) should be reported in accordance with JSP 751. The preferred method is via JPA, and arrangements exist when this is unavailable. This is important not only for the correct notification of casualties, but also to enable accurate statistics to be collated informing future policy and practice.

g. In the event that an individual, is considered to be at high risk of DSH or potential suicide is missing from a unit and unaccounted for, the Management Algorithm at Appendix 3 to Annex 24D is to be followed.

h. In the event that a death or serious injury is discovered, immediate action must be taken at the scene, to minimise and prevent further injury, and to maximise the opportunity to secure evidence. Annex 24E refers in detail.

i. A Service Inquiry is likely to be necessary following any incident where death or serious injury occurs, BRd 2 Chapters 53 and 57 refer. JSP 832 sets out the circumstances where a Service Inquiry is required and provides the definitive guide.

j. If a Service Inquiry is not required but a DSH episode was significant, then an RN Ship's Investigation, or RM Unit Inquiry, can be ordered to establish what has happened and determine recommendations to prevent recurrence. BRd 172 (The Yellow Guide) provides guidance.

4. Subsequent Management of DSH Episode

a. The management of the initial phase of a DSH case will be determined by the mental health risk assessment. The risk presented, location and time will all be factors in the appropriate course of action. It is essential that there is close liaison between the assessing Medical Officer/Medical Branch Rating, who has access to specialist mental health support, and the Executive.

b. A referral to Defence Mental Health Services[1] via the appropriate Departments of Community Mental Health is considered best practice, Appendix 1 provides necessary

[1] JSP 950 Vol 2 Ch 7 Lft 2-7-2 Defence Mental Health Services

details. Consideration should be given to medically downgrading such cases as Medically Non-Deployable; JSP 950 provides in depth guidance to Medical Officers.

c. In the deployed environment consideration should be given to aeromedical evacuation to the UK. In this situation it is imperative that the RAF Aeromedical Evacuation System is used, which provides appropriate in-flight supervision based on the risk assessment. AP3394 describes the process in detail. Should an individual need to be landed in a foreign port pending aeromedical evacuation, then specialist guidance is essential. Close liaison will be necessary between the appropriate embassy, compassionately ensuring the safety and well-being of the individual.

5. Executive Management

a. In cases of DSH, the Executive will need to liaise closely with the Medical Service to ensure appropriate case management, while maintaining the necessary duty of care. The most significant factors are:

(1) Maintenance of a safe environment permitting medical assessment.

(2) Investigation as necessary through either a Service Inquiry or Ship's Investigation.

(3) Ongoing liaison engagement with Case Conferences to facilitate appropriate multidisciplinary care.

(4) Input into psychiatric assessment of future employability through an Occupational Report (FMed1041).

(5) Application for Discharge (SHORE) or Services No Longer Required if appropriate.

(6) Disciplinary Action as required.

b. **Security Implications.** If an episode of DSH raises concerns relating to security, then the Unit Security Officer should be involved and act in accordance with JSP 440 The Defence Manual of Security[2].

c. Appendix 2 contains a flow diagram illustrating the process and possible outcomes.

6. Multidisciplinary Care

a. As described, most cases of DSH are communications of distress and need. In addition to appropriate medical management, wider avenues of support may be utilised to provide the correct care.

[2] https://modgovuk.sharepoint.com/sites/InternetHeadOffice/SitePages/JSP-440.aspx

b. **The Divisional System.** An individual's DO should be involved in all cases of DSH. The bond created by the Divisional System can be a strong resource for the individual in distress and may facilitate simple adjustments that provide immediate relief. Furthermore, the DO is in a key position to inform the Medical Service on aspects of the case that are not immediately apparent and also provide liaison with the unit Command.

c. **Royal Navy Family & People Support.** Many cases of DSH are caused by psychological distress, and the source of this is often located in relationship, family and financial matters. RN FPS can be contacted by either a unit Chain of Command or the individual themselves via a single point of contact in HMNB Portsmouth, from where suitable support and intervention can be co-ordinated. Chapter 24 refers. Contact:

RN FPS Portal: 0800 145 6088 or via email: Navypeople-psmfpsportal@mod.gov.uk

d. **Chaplaincy.** Unit Chaplains are able to offer pastoral care and support, regardless of religious beliefs. Chapter 31 refers in detail.

e. Chapter 24 Section 9 and Section 10 contain details of organisations that are able to offer additional advice and support.

7. Case Conference

Once the initial management of the DSH episode described above has been completed, a Case Conference should be convened. This shall consist of representatives from the Medical Service and Divisional System, as well as other agencies involved in the individual's care such as RN FPS. The aim is to align assessment of the situation, contain and control any risk, and plan the future management. Appendix 3 gives those involved further guidance.

8. Confidentiality

a. The correct maintenance of confidentiality is essential for successful ongoing management. The agencies typically involved in the management of DSH cases will have specific policies on managing confidentiality, which can be enshrined by professional regulatory bodies. The General Medical Council, for example, state that a Medical Officer could disclose personal information if:

(1) It is required by law.

(2) The patient gives consent.

(3) It is justified in the public interest.

b. Issues surrounding confidentiality can be challenging. Written consent should be obtained where possible, and even then, relevant information should only be shared with those who need direct knowledge of the situation.

9. Long Term Outcomes Following DSH

a. The RN has a duty of care to correctly manage individuals who present with or threaten DSH. The appropriate course of management will depend on numerous factors and will initially be guided by the presentation and risk assessment. In the longer term, both the needs of the individual and the Service will influence the outcome.

b. Where possible, the goal of any long-term management will be to harmoniously return the individual to a state of psychological resilience and Service employability. In some circumstances and situations, the correct pathway may ultimately lead to discharge from the RN through Medical, Welfare or Executive routes. This will be driven in part by the initial motivation of the DSH, and ultimately the overall Service prognosis which will be informed by the Case Conference.

10. Medical Outcomes

As DSH is a communication of distress and need, it is not a diagnosis as such. An individual cannot therefore be medically discharged from the Service for DSH alone. Recurrent DSH is however typically associated with significant psychiatric illness or personality dysfunction, and the correct management is that for the underlying disorder. If, after appropriate treatment, such a presentation persists, then consideration for medical discharge may become appropriate. JSP 950 provides in depth guidance to Medical Officers.

11. Welfare Outcomes

An episode of DSH may be the first indication that the individual is experiencing an overwhelming amount of distress. The source of this is often in their personal life, for example relationship breakdown, family discord or financial pressure. RN FPS is able to provide management and support with these issues, which could ultimately lead to a Compassionate Discharge.

12. Executive Outcomes

a. **Warnings.** In cases where Executive management is necessary, an individual will typically be placed under Warnings as described in Chapter 57.

b. **Discharge SHORE.** Discharge SHORE is not a punishment. It is the normal method of dispensing with the services of ratings and other ranks whose retention is undesirable due to unsuitability or possibly for reasons largely beyond their control. Chapter 54 details the circumstances in which Discharge SHORE may be appropriate. In cases of DSH these can in particular include:

(1) **Temperamental Unsuitability (TU).** TU describes an individual's persistent and obvious failure to adapt to the basic but unique demands of Service life. These demands include tolerance of separation from family, naval discipline and military hierarchy, the need for self-discipline and close quarter living. The distress caused by such a failure to adapt can manifest itself through acts of DSH, usually early in a Naval career.

The Executive has the option of applying for Discharge SHORE on the grounds of TU. For this to be pursued, an individual must be assessed by a Service Medical Officer or Civilian Medical Practitioner and a recommendation for a TU discharge be provided in writing to the Commanding Officer. Prior to this assessment, an FMed1041 will be required, signed by the Commanding or Executive Officer, stating that other appropriate avenues of support or discharge have been considered. Annex 54D describes the assessment of TU in detail.

(2) **Alcohol.** Alcohol abuse and dependency can exist in the absence of a distinct mental disorder which necessitates medical management and potential medical discharge. These situations are complex and require close co-ordination through the Case Conference. Problems related solely to alcohol abuse may be ultimately managed through Discharge SHORE.

(3) **Inadequacy.** Ratings and other ranks may be unable to perform the duties of the lowest rate to which they can be reverted. Difficulty managing the distress this causes can present through DSH and Discharge SHORE may be the most appropriate management.

(4) This is not an exhaustive overview of Discharge SHORE and other circumstances exist, as described in Chapter 54.

c. **Naval Discipline.** It can be the case that an episode of DSH is consciously motivated to influence people and alter events, without any suicidal intent or underlying mental illness. An example of this would be a wilful injury sustained purely to achieve a medical downgrade thus preventing an individual's deployment. The Armed Forces Act 2006 provides the Executive with recourse to manage such cases under Section 16 Malingering or Section 19 Conduct to the Prejudice of Good Order and Service Discipline.

d. **Discharge Services No Longer Required.** Discharge SNLR is not a punishment, but neither is it an honourable release and can impair a rating or other rank's prospects of employment on return to civil life.

(1) **Unruly.** Usually there will be evidence that an individual is on Warnings for Discharge SNLR (Unruly) and has received previous punishment that has not had the desired reformatory effect. Cases of DSH with the desire to influence individuals or outcomes may be particularly challenging to manage.

(2) **Drug Misuse or CDT.** Some cases of DSH may present with drug misuse, which is incompatible with the unique situation of Service life.

e. **Officers.** Officers may equally present with DSH and ultimately require Executive management. Appropriate mechanisms of discharge exist as described in Chapter 54.

f. This description of avenues of Executive management is not meant to be exclusive or comprehensive but serves to describe the more common routes seen in such cases.

g. Such Executive actions will require clear co-ordinated input which is harnessed through the Case Conference.

APPENDIX 1 TO ANNEX 24D

GUIDANCE TO MEDICAL PROFESSIONALS

1. Introduction

This Appendix provides detailed guidance to Medical Officers/Medical Branch Ratings on the management of cases of DSH in the immediate and longer term. All healthcare professionals should be accountable for their actions, and act within the limits of their professional competence. Those operating under supervision (for example General Duties Medical Officers) should discuss all such cases with their seniors.

2. Responsibilities

a. The initial management of any immediate physical injury or illness.

b. Full mental health risk assessment, documented on the Defence Medical Information Capability Programme patient record.

c. Initial liaison and referral to specialist mental health care.

d. Raise a NOTICAS iaw JSP 751 Vol 1 Ch 5.

e. Providing informed advice to the Executive regarding the ongoing management.

f. Participation in Case Conferences as detailed in Appendix 2.

3. Risk Assessment Following DSH

a. Following an act of DSH, a mental health evaluation and risk assessment will need to be conducted by the Medical Officer/Medical Branch Rating. The requirements of a psychiatric history and mental state examination are described, which in turn inform the ongoing risk assessment.

b. **Mental Health History:**

(1) **History of Presenting Complaint.** In these cases, this will include the patient's own account of events leading up to the DSH episode and provide much of the information needed for the risk assessment.

(2) **Past Psychiatric History.** Including past diagnoses, treatment and severity. Previous episodes of DSH are also highly important.

(3) **Past Medical History.** Particularly noting the presence of chronic, disabling, or terminal disease.

(4) **Medication History.** Medication taken for whatever reason should be noted. Consideration of substances potentially toxic in overdose is particularly important.

(5) **Social Circumstances.** DSH can often occur in the context of social disharmony including relationship breakdown, family or financial distress.

(6) **Service History.** Occupational role and functioning, particularly access to weapons and safety critical tasks, are important considerations.

(7) **Forensic History.** In the Service context this includes interaction with the civil police, and the Executive.

(8) **Substance Use.** Alcohol use, misuse and dependence should be assessed, as well as the use of illicit drugs or other psychoactive substances.

(9) **Personal History.** This includes early life, upbringing, and enduring patterns of interaction with the world.

c. **Mental State Examination.**

(1) **Appearance and Behaviour.** Noting self-care, dress, rapport and appropriateness of interaction.

(2) **Speech.** Presence or absence of formal thought disorder, and pressure or poverty of spontaneous conversation.

(3) **Mood.** Subjective and objective assessment of mood, and appropriateness to current circumstance.

(4) **Thought Content.** Including presence or absence of delusions or overvalued ideas. Coherent and logical thinking patterns should also be considered.

(5) **Perceptions.** Hallucinations or illusions in any sensory modality.

(6) **Cognition.** Cognitive state including orientation, concentration and memory.

(7) **Insight.** Individual's own view of their presentation and willingness to receive offered interventions.

d. **Risk Assessment - Suicidal Intent of the Act**

(1) **Were precautions taken against discovery?** When an individual act of DSH is undertaken and the individual knows it will be discovered before any significant health effect could occur, it presents a lower risk, for example cutting an arm in the messdeck. When DSH occurs in isolation and is not expected to be discovered, it presents a higher risk.

(2) **Was the act pre-meditated?** Prior planning, such as the stockpiling of medication, represents intent and presents a higher risk.

(3) **Were final acts completed?** Putting affairs in good order represents a higher risk of suicide, overlapping with planning in advance. Preparing a will or life insurance indicates an intent; however handwritten notes can be made quickly and easily.

(4) **Was the act likely to cause death?** A violent act, such as hanging or jumping from a height, indicates a much higher risk of future suicide. It is important, however, to assess the understanding of intent as it is the believed likelihood of causing death that is important. Thus, an overdose of 4 paracetamol tablets might genuinely be understood to be potentially fatal.

(5) **Was the act impulsive?** An impulsive act such as an overdose directly following an argument with their spouse may represent a lower risk of suicide.

(6) **Did the individual summon help themselves?** Calling for assistance following DSH is a protective factor, for example contacting family via mobile telephone to tell them what has happened.

(7) **Was the individual under the influence of alcohol or drugs?** Individuals who experience distressing life events often use alcohol or other psychoactive substances to manage their emotions. This use can lead to impulsive, spontaneous and irrational actions. When distressed and under this influence, unplanned and impulsive acts of DSH can be performed, sometimes following an interpersonal argument which, unintentionally, can be serious.

e. **Risk Assessment - Significant Risk Factors**

(1) **Previous History of DSH.** As identified, the risk of a completed suicidal act is much higher in those with a history of DSH, with or without clear suicidal intent at that time.

(2) **History of Significant and Current Alcohol or Drug Misuse.** The behavioural alterations relating to recklessness and impulsivity when influenced by psychoactive substances place those who use them at a significantly higher risk of future DSH and suicide.

(3) **Presence of Significant Mental Illness.** DSH and suicide are linked to a myriad of psychiatric disorders. The full history and mental state examination will permit the identification of mental illness.

f. **Risk Assessment - Ongoing DSH Risk**

(1) **Does the individual regret the attempt?** Regret and remorse following an act of DSH indicates a lower risk of a recurrence.

(2) **Assurance given of future safety**. If an individual can assure those assessing their ongoing risk that they are confident in keeping themselves safe, this indicates lower risk.

(3) **Ongoing suicidal ideation, plans or intent?** If, on assessment, the individual retains thoughts or desires to harm themselves then the future risk is elevated. An absolute future intent to complete suicide presents a much higher risk.

g. **Risk Assessment - Protective Factors Which May Reduce the Future Risk**

(1) Presence of family and friends, rather than social isolation.

(2) Having children or dependants.

(3) Ability to see a positive future, instead of hopelessness, is protective.

(4) Stating reasons to live, other than those above, can also be reassuring.

(5) Moral objections to DSH and suicide.

4. Documentation of Assessment

Medical Officer/Medical Branch Ratings should carefully document their full risk assessment on DMICP.

5. Specialist Support to Medical Professionals

a. Medical Officers/Medical Branch Ratings can access specialist support to manage these complex cases in the initial phases. All DCMHs provide a duty nurse who is available for advice and guidance. In hours (0800 – 1700 weekdays excluding bank holidays) contact should go through the appropriate Base Port DCMH contact number below.

HMNB Portsmouth: 07929 767 024

HMNB Plymouth: 01752 555 965

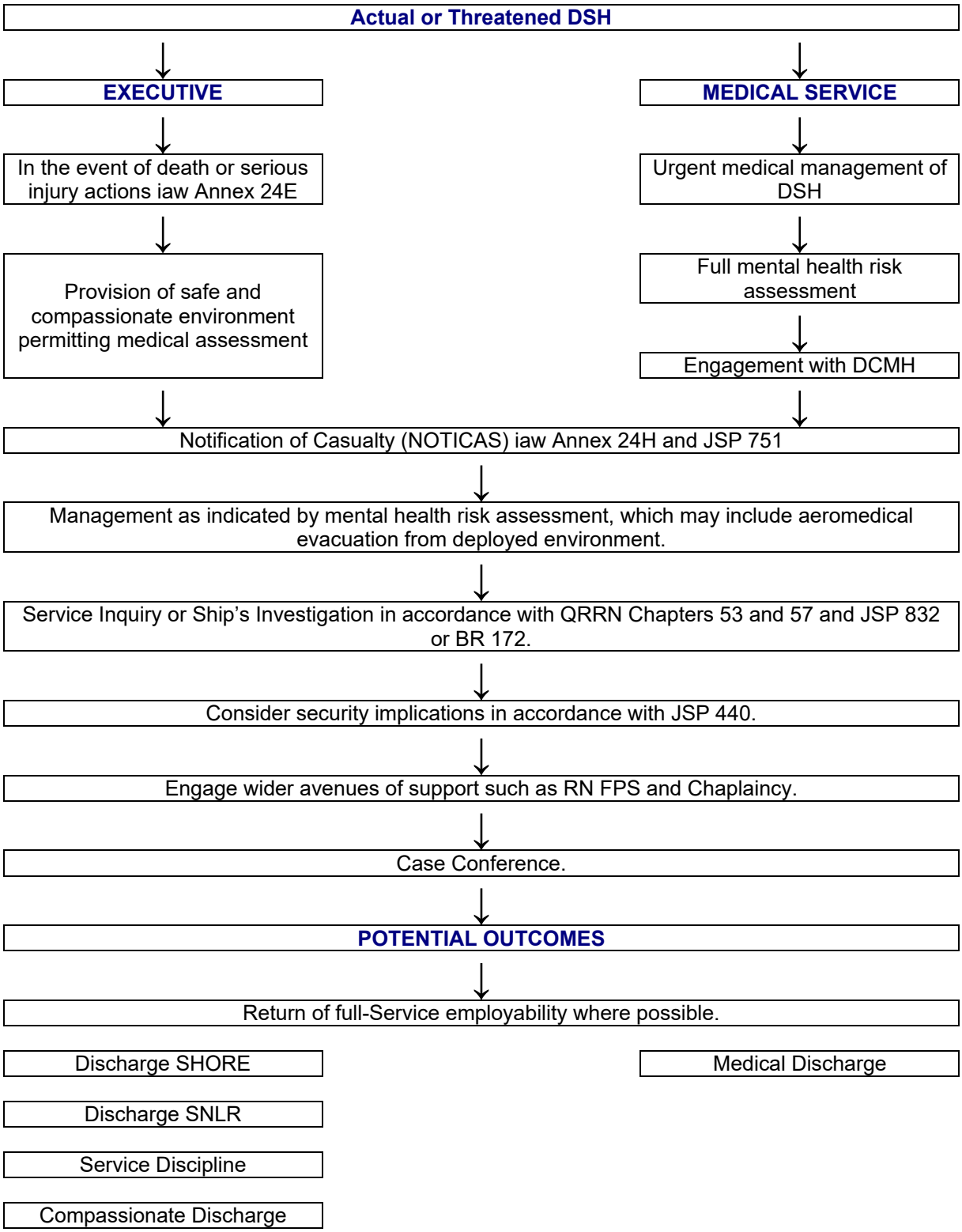
HMNB Clyde: 07814 901 381

b. In addition, there is a national tri-Service contact telephone number for out-of-hours mental health advice: 01543401141. This number is for clinicians only and not CoC or SPs.

c. It is now widespread best practice that all cases of DSH are referred for specialist assessment and management to the appropriate DCMH through DMICP. Referral will be through local processes, which is usually to a Single Point of Access (SPA) within the regional Defence Mental Health Network (DMHN). The risk assessment will inform the urgency of this, and a telephone call should accompany cases where necessary.

APPENDIX 2 TO ANNEX 24D

MANAGEMENT ALGORITHM 1



APPENDIX 3 TO ANNEX 24D

CASE CONFERENCE

1. Membership

The Case Conference is a key step in correctly managing cases where DSH has occurred. This will typically take place after the initial episode and when ongoing avenues of care have been explored. Key members of the Case Conference are as follows:

a. **Executive Representation:**

(1) To chair the Case Conference.

(2) To provide perspective on individual case and needs of the Service.

(3) The exact position of this member will vary with situation but, in a ship for example, should be the Executive Officer.

b. **Divisional Officer:** To promote the needs of the individual.

c. **Unit Medical Officer:** To represent the medical situation.

d. **DCMH Representation:** To provide specialist mental health opinion.

e. **RN FPS:** If involved.

f. **Chaplaincy:** If involved.

g. Any other relevant agency.

2. Individual Engagement

The individual concerned must be made aware that the Case Conference is to be held, and they should be given the option to participate for some or all of the proceedings. Engagement with the individual concerned is a key factor to delivering an effective care management plan.

3. Structure

The following structure to the Case Conference is intended as a guide:

a. **Introduction.** All participants should introduce themselves by name, role and nature of input.

b. **Presenting Situation.** The events that led up to the DSH episode, and what has occurred since, should be discussed in order to allow participants to share information and understanding. This will be led by the professional who has best grasp of the situation, which may be the Divisional Officer or Medical Officer.

c. **Medical Assessment.** Prior to the Case Conference, informed consent must be sought from the individual to disclose medically confidential information in accordance with GMC guidance and Caldicott principles. Key aspects of the medical contribution will include the nature of any underlying mental health disorder and the ongoing risk assessment. Medical downgrading needs to be explicitly discussed, considering Service prognosis.

d. **Executive Assessment.** Both the Divisional Officer and Executive representative will inform the Executive assessment aspect of the case conference. The individual's Service Record should be considered, along with any discipline actions in process such as Warnings.

e. **Additional Information.** This will include input from other agencies such as RN FPS and Chaplaincy. Here any child or vulnerable adult safeguarding concerns should be highlighted.

f. **Individual's Perspective.** If present, the person concerned can express their own views. If they do not wish to participate with the full conference, they could be invited to join at this stage.

g. **Management Plan.** The overall management plan is to be discussed and agreed upon. This will incorporate the needs of the individual and future Service employability. The plan will be multidisciplinary and involve co-ordination for delivery.

h. **Documentation.** All members will need to make notes for their agency's documentation requirements upon completion. The Medical Officer must make an electronic record on DMICP, noting particularly the ongoing risk management plan, as this constitutes an agreed care plan.

APPENDIX 4 TO ANNEX 24D

MANAGEMENT ALGORITHM 2

Actual or suspected DSH when the location of subject is unknown and they are thought to have left the base

EXECUTIVE

Divisional Officer to inform Duty Staff & Guardroom

Divisional Officer to phone the Civilian Police at the earliest opportunity.
(The Police will allocate a Missing Person Liaison Officer)

Civilian Police 11 Questions for Missing Persons

1. Where was the person last seen?
2. What are the circumstances of the person going missing?
3. Description. Gender, ethnicity, age, height, build, hair colour, clothing, distinctive features and footwear.
4. Does the missing person have access to a mobile phone?
5. Is there any indication that the missing person is suicidal or is at risk of harming themselves?
6. Does the Missing Person have any other medical needs or MH concerns?
7. Are these circumstances out of character?
8. Have hospital/Police Station checks been carried out?
9. Does the Missing Person have access to a vehicle?
10. Does the Subject have any access to money or bank cards?
11. What has been done to trace the individual so far?

(It is better to pass information early than await full facts and pass the information too late.

Notify additional personnel if appropriate: RNP, Padre, RN FPS, Medical Centre [1]

Unit staff to continue to search for the subject and co-ordinate with the Police and Emergency Services.

Emerging evidence surrounding the circumstances of potential/actual DSH to be immediately passed up through the CoC.

[1] RN FPS, Medical Services, and Padre may be able to provide context on whether the individual was experiencing any specific issues that the CoC were not aware of that could assist with building the picture

ANNEX 24E

DEATHS AND SERIOUS INJURIES IN UNITS AND ESTABLISHMENTS

References:

A. 2010DIN02-023
B. BRd 2
C. JSP 751

1. Introduction

There may be occasions when personnel will discover a serious incident involving death, or where death is likely. In these cases, a local Home Office Police Force inquiry will normally follow. Depending on the proximity of the police to the incident it may be some time before the police attend the scene and take control. The following guidance and aide memoir should be disseminated widely to all ranks / non-police personnel and form the basis of more comprehensive unit SOPs. This ensures correct procedures are carried out and minimises and/or prevents further injury whilst maximising the opportunity for the police to secure evidence.

2. Initial Action to be taken by Non-Police Personnel

On discovering an incident involving death or where death is likely, the following action is to be taken:

a. **Prevent Further Loss of Life (Including Your Own) or Injury.** The main priority on discovering an incident is to prevent further loss of life or injury. The senior person unconnected with the incident is to assess the situation, take charge and take appropriate and safe action to:

(1) **Ensure area is safe to enter.** Identify and eliminate any danger, where safe/minimal risk to do so, e.g. extinguish a small fire, isolate electrical currents etc.

(2) **Remove the injured person away from imminent danger.** For example, assist people from a smoke-filled room. However, under no circumstances must a seriously injured person be removed if there is no imminent danger as this could cause long-term medical problems or fatality if not handled correctly.

(3) Tend the injured.

(4) Seek medical or other assistance at the first available opportunity.

(5) Once further loss of life or injury has been prevented, any injured personnel at the scene should be tended in accordance with current training.

(6) Where practical, those suffering from shock, trauma or distress should not be left alone or in circumstances where they could further injure themselves or others.

(7) Only a Medical Officer can certify death at the scene and therefore every effort should be made to revive or treat personnel until tended by trained medical staff. Where it is obvious that a person is dead and cannot be revived the deceased should remain exactly as discovered and not touched or moved.

b. **Uninjured Personnel at the Scene.** They should be segregated and should normally be asked to remain at the scene until the arrival of the police; the person discovering the injured or deceased person is a key witness, who police will wish to interview at the earliest opportunity. The details of those personnel who are possible witnesses or suspects should be noted. Those person(s) involved, or suspected to be involved, in an incident or found at or near a scene should be asked or ordered, where the necessary authority exists, not to wash themselves or their clothes until seen by the police.

c. **Take Appropriate Measures to Protect the Scene.** It is vital that, when the police arrive, the scene (and everything within it) is exactly as it was discovered. In particular:

(1) **Offices, Accommodation, etc.**

(a) Where the scene of an incident is under cover it may be able to be secured by locking the entrance/exit doors. Windows are not to be closed, unless under exceptional circumstances, i.e. weather etc. They may be a point of entry/exit for a suspect and therefore may provide forensic evidence. If the incident involved a jump or a fall, windows should not be touched and should be left exactly as they have been found.

(b) If possible or practicable, a sentry should be placed on windows to ensure no interference with such possible evidence. Any other methods of entry or exit should be secured, and the room/area cleared of all other occupants. Thereafter, the key must be retained by a person in authority until the arrival of the police. It is also important that the room/building remains undisturbed, and those occupants (or other unauthorised visitors) are not allowed access to the room/area either deliberately or accidentally, for any reason.

(c) Should it be suspected that other keys to the area exist or you have any doubts over your ability to fully secure the scene you should position a guard(s) at the points of access/exit.

(2) **Outside Areas.** Where it is not possible to secure the area by utilising existing physical barriers, access to the area by unauthorised personnel should be physically prevented. At the first opportunity a cordon using personnel or ‘mine tape’ should be placed at a suitable distance around the scene. The type of incident and area will determine the size of cordon.

(3) **Visitors.** It is important that only personnel required to attend the scene are allowed within the cordon. Those personnel not connected to the incident or who have no legitimate purpose at the scene must not be allowed into the scene and should be instructed to leave the area. A record of all persons attending the scene within the cordon is to be recorded with their reason why, and handed to police on arrival. If a person does need to enter scene they must be escorted to ensure they do not tamper with evidence. There are few reasons why access should be required to the scene, and unless there are Health and Safety reasons there should not be any need for anyone to enter the scene once initial actions have been taken.

(4) **Pets.** If applicable, remove any pets from the scene.

d. **Preserving the Scene.** It is essential that anything at the scene is found by the police. Under no circumstances should the area be cleaned and any items at the scene should be left in the same condition and position as they were discarded. In particular:

(1) **IEDs/Suspect Packages, Etc.** These should remain in situ and under no circumstances should these be examined, removed or tampered with. The use of mobile phones, other communications or bright lights (flashlights etc) is to be avoided.

(2) **Firearms.** These should not be touched, handled or moved, made safe, unloaded, cleaned or tampered with in any way. It will be important that the police find any firearm in the same condition as it was left. Care must be taken not to touch bloodstained items as blood distribution and ballistics may be a factor. If you have handled the weapon or know that any other person has, you should notify the police immediately on their arrival. The weapon should only be touched and made safe by a Police Firearms Officer.

(3) **Spent Cases.** These should not be touched, handled, moved or collected. A large cordon should be established in order to encompass any such evidence. The searching of the cordoned area should be left to the specialist Police search teams. A search conducted by any other persons may damage evidence or introduce foreign items into the cordoned area which may contaminate the scene.

(4) **Knives or Other Weapons.** Knives (or other weapons if appropriate) should not be touched, handled or moved.

(5) **Documents.** Any notes, whether sealed or otherwise, and any other correspondence or documents found at the scene should not be handled and must remain undisturbed. Be mindful that the note could have been written by someone other than the deceased and may require detailed forensic analysis. If the note has been handled, establish when, where and by whom and report this to the police on arrival.

(6) **Electrical Equipment (Including Computers/Mobile Phones/Radios/Flashlights).** Any electrical equipment found should not be tampered with, switched on/off, used or removed.

(7) **Clothing/Garments.** Are not to be removed from the scene or injured personnel (unless for medical reasons by trained medical staff).

(8) **Blood/ Bodily Fluids etc.** Blood and other bodily fluids stains and marks should be left in situ. Unless taken to a medical facility with the patient for emergency treatment, all body parts should be left at the scene until the arrival of the police. Nothing should be cleaned until the arrival of the police.

(9) **Hanging.** The important areas from a forensic point of view are the knot itself, the position on the neck and the point of suspension. If the ligature has to be cut, other than in an emergency, it should be cut on a central point and well away from these areas.

(10) **Overdose.** The container and any remaining drugs should be noted but left in situ.

(11) **Carbon Monoxide Poisoning.** If a car window has to be smashed to gain entry to a vehicle select one other than the drivers or the window through which the hose is running. Note the position of the body, its condition and any smell coming from the car. If the engine is running, turn it off and leave the keys in the ignition, no further action should be taken

3. Reporting

a. It is important that personnel discovering an incident report it and obtain assistance at the earliest practical opportunity. Once in a position to do so personnel should report the incident to a person in authority, i.e. duty staff/police etc, by the quickest and safest means possible, e.g. mobile telephone, in person etc. Where two people, unconnected with the incident, are present one should remain to protect the scene whilst the other reports the incident and/or seeks assistance.

b. Duty military personnel notified of an incident should ensure that the action above has been completed and immediately report or arrange for the details to be reported to:

(1) In the UK, local Home Office Police, Service Police and/or MDP. Overseas the Service Police.

(2) The Chain of Command (in accordance with local SOPs).

ANNEX 24F

TRI-SERVICE SPECIALIST WELFARE AGREEMENT ON MUTUAL WORKING AND AREAS OF RESPONSIBILITY

1. Preamble

The provision of Specialist Welfare Support, in accordance with JSP 770, is a responsibility of the parent Service Command, but there will be occasions when another Welfare provider is able to meet the needs of the Service user most effectively. Initially support must be sought by the Service User via their own Service welfare provider. Once it is established they are unable to provide the most appropriate support, the owning welfare provider is to request transfer of care to the welfare service identified as more appropriate. Compassionate action, assignments, discharge or services provided at Public expense must involve the parent Service Chain of Command.

2. Parties

This agreement is between Royal Navy Family & People Support (RN FPS), the Army Welfare Service (AWS), and Royal Air Force Community Support[1]. In this document these specialist organisations are referred to as agencies, 'Service' refers to the single Services (Royal Navy, Army, RAF) and 'services' to the various outputs that the agencies provide.

3. Scope

a. This agreement covers services to Serving personnel and their families in the following situations:

(1) Specialist welfare services for personnel serving with a unit of another Service and their families, where appropriate, will be provided by the local service welfare agency.

(2) Where, due to geographic or other reasons, services would be more appropriately provided by another agency.

b. This agreement does not cover:

(1) Work that is, or is likely to be, particularly sensitive or of high profile or particularly complex, with single Service implications. Receiving agencies should be aware of such sensitivities and discuss them with the appropriate Service agency at the earliest opportunity.

(2) Counselling or other services purchased for specified individuals at public expense. Funding approval and associated costs lie with the parent Service.

(3) Social Inquiry Reports (SIRs) and pre-sentence reports must reflect the Service of the convening authority, although elements of such reports may be conducted by a co-operating agency.

[1] Specialist RAF Community personal and emotional support services are provided by SSAFA-FH(RAF) under contract arrangements.

(4) Out of hours services that may not be provided by other specialist welfare agencies.

4. Case Conduct

a. Each organisation will allocate work, carry out the assessment and make recommendations in accordance with that organisation's processes and criteria, consulting as necessary. The case will be conducted as any other of the organisation's cases, including coverage within supervision and confidentiality policies.

b. Where a recommendation requires funding, compassionate or Executive action by the individual's Service, the individual's consent will be sought before information is passed to their own Service welfare organisation, which will refer to the appropriate Service authorities for action (modifying it to conform with own Service criteria if necessary). The decision on the recommendation in such cases remains with the individual's Service. If the individual withholds consent for information to be passed on, it will not be possible to recommend compassionate or Executive action.

ANNEX 24G

ESTABLISHING AND MAINTAINING AN ON-LINE COMMUNITY

1. Introduction

The Royal Navy Forum (https://forum.royalnavy.gov.uk) is the Royal Navy's OFFICIAL place for online Family Engagement, providing a fully accredited and secure area to keep members informed/involved/in touch with Navy Command, RN FPS and other stakeholders. The RN FPS also use a RN approved Facebook Page and X account to inform and signpost families to the RN Forum.

2. At Least Three Months Prior to Deployment

a. Units must establish contact with RN FPS for a brief on the Royal Navy Forum in order for them to communicate and engage safely with their families. Email: rnrm-wio@royalnavy.mod.uk or navypeople-psrnfpsinfo@mod.gov.uk.

b. The Unit is to provide a single point of contact to act as the Families Liaison Officer (FAMLO). The FAMLO role should be allocated to an individual who has the experience to identify what is of concern and interest to families and who appreciates how valued the FAMLO role is likely to become amongst the on-line community. They should be accountable to the Executive Officer/Adjutant.

c. The Unit is to identify a Forum Liaison Officer/s (FLO/s) to support in the regular engagement with their families via their Royal Navy Forum space. This could be the FAMLO or someone who works in conjunction with them. It is very much up to the Unit how many FLOs are nominated. Once identified, details are to be sent to rnfpsmediamailbox@royalnavymail.mod.uk.

d. The RN FPS Digital Moderators will ensure profiles are set up for the FAMLO and FLO(s) to ensure anonymity. This will ensure admin tools are accessible to them and training on how to use is completed.

e. It is also mandatory for the Unit to contact RN FPS to book in an Initial Meeting with the RN FPS Deployed Assets Team (navypeople-psrnfpsdeployed@mod.gov.uk) in order to organise the delivery of the mandatory RN FPS briefings: pre-deployment brief (Unit Personnel and separate Family brief) and return and reunion (prior to homecoming), arrange attendance at Families' Days to promote the RN Forum and discuss other areas of RN FPS deployment support.

3. One Month Prior to Deployment

One month prior to a deployment, Commanding Officers are asked to release a letter to families, informing them of the Royal Navy Forum – https://forum.royalnavy.mod.uk, strongly encouraging them to join the Unit's group. This will ensure they are kept up to date with the Unit whilst deployed, give them the ability to ask questions, and meet/gain support from their peers.

4. While Deployed

a. During the deployment, RN FPS staff will, if appropriate, provide support for events for the Ship/Unit's on-line community. These can be virtual events (such as on-line gatherings at a specified date/time), or actual events. Interaction on-line often leads to increased face-to-face activity.

b. RN FPS will provide an annual calendar of events for deployed families utilising the Family Welfare Grant. These will be added to the Royal Navy Forum with booking forms. Invoicing of these events will be direct with OWP – Finance.

c. The RN Forum will be the resource that families will look to for accurate and regularly refreshed information regarding 'their' Ship/Unit. Such material promotes involvement and a sense of identity with the Ship/Unit and its people, but successful engagement depends on the flow of material via the FAMLO/FLO. There is, for instance, limited interest for families in a missile launch, whereas being able to spot loved ones in a picture of a team at work generates a much more positive reaction. The appetite of the on-line community to feel part of the personal experience of loved ones on deployment cannot be overestimated. Replication of material which is used for public consumption on the Royal Navy website or X Accounts does not achieve that purpose. Posts do not have to be time consuming, such as a newsletter. Several short posts with images on a regular basis is better than a full newsletter once a month. Short bitesize videos are also welcomed, and these will be held within the RN FPS YouTube channel as unlisted with links added to the members' area of the RN Forum. RN FPS can provide some ideas that are seen as best practise if required.

d. Whilst the FLO can post themselves the RN FPS Digital Moderators (DM) are at hand to support. They maintain a duty system (0800-2200, 365 days per year) that allows information to be updated speedily, thus ensuring that rumours, speculation and consequent anxiety is kept to a minimum and that families are kept involved and informed as fully and accurately as possible. Email: navypeople-psrnfpsmedia@mod.gov.uk. The DM will also highlight any identified anxieties to the FLO if required.

e. RN FPS Engagement & Communications SO2 works closely alongside RN Media and Comms, which means RN FPS are in a good position to publish information to families in the event of any incident involving the Ship/Unit as soon as it is released by MOD and, hopefully, before publication in the press.

f. In the event of open communications from the Ship/Unit being suspended, the Duty DM will become the conduit for continued communication with the families on the RN Forum. The DM will communicate with the Ship/Unit when permitted, representing the Ship/Unit until normal communications are reinstated. A message can be placed into the Unit group should you have notice of any suspensions to communications. It is also worth noting that when 3rd Party Social Media is not available due to certain circumstances, the members' area of the RN Forum can still be used.

ANNEX 24H

ROYAL NAVY NOTIFICATION OF CASUALTY (NOTICAS) DIRECTIVE

1. Introduction

a. This Directive should be used in conjunction with the overarching Joint Policy and Procedures[1].

b. The MOD places the utmost importance on the way the Services deal with casualties. Casualty reporting must be undertaken as quickly and sensitively as possible, and takes precedence over all but the most urgent operational and security matters.

c. The casualty reporting and notification process is coordinated by the Joint Casualty and Compassionate Centre (JCCC) and all information must be routed through that Centre.

d. As the sole Notifying Authority (NA), the Royal Navy Casualty Cell (RNCC) takes the lead in the management of the process for all Royal Navy (RN) casualties[2].

2. Casualty Reporting

a. **Raising a NOTICAS.** A full list of occasions of when a NOTICAS is mandated is at Appendix 1. An example of a NOTICAS is at Appendix 2 and a NOTICAS template at Appendix 3.

b. Raising the NOTICAS **is the responsibility of the casualty's parent unit** and is an Executive function. It is for the unit to establish who is to raise the signal eg. OOD in consultation with Duty Medic out of hours and Medical team during office hours. A step-by-step guide to the notification process is at Appendix 4.

c. The primary method for reporting casualties to JCCC is the Casualty Notification (NOTICAS) signal on JPA. If JPA is unavailable, the unit must send a NOTICAS to JCCC Innsworth by immediate signal.

d. Accuracy must not be sacrificed for speed; it is therefore essential that no unverified information is included in the NOTICAS. If doubt exists, the relevant section must be left blank and the information, once verified, reported via subsequent updates.

e. **Maritime Reservists.** Casualties involving on duty Maritime Reservists (MR) will be managed in the same way as their regular counterparts. Incidents/casualties involving Off duty MR are a civil police matter, however their parent MR Unit should immediately report any casualties to their respective MR HQ (RMR/RNR SO2/SO1) who will then inform the RNCC, JCCC (SO2 Post Death Admin for release of any Service Wills) and Commander Maritime Reserves.

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[1] JSP 751 – Joint Casualty & Compassionate Policy & Procedures, Management of the Casualty, Volume 1 and JSP 751 – Joint Casualty & Compassionate Policy & Procedures, Management of the Deceased, Volume 2.
[2] With the exception of Special Forces personnel who are managed under a separate policy.

f. **Adventurous Training/Expeditions.** For any overseas RN Adventurous Training (AT) activity or expedition, a copy of the Admin Order and nominal roll must be sent to JCCC (DBS-JCCC Group Mailbox (MULTIUSER)) before the event. This is to allow JCCC to track who is in/out of the country and speed up the NOTICAS process in the event of a casualty.

g. **NOTICAS of UKSF.** There is a separate NOTICAS procedure for UKSF.

3. Casualty Notification

a. KINFORMING is the process of notifying the EC/NOK of RN casualties. Kinforming via the RN NA will take place only under specific direction from the RNCC (ie. once it is in receipt of a NOTICAS from JCCC tasking RNCC to begin the process).

b. **Casualty Notification Officers (CNOs).** In cases where the casualty is dead, missing, VSI or SI (see Appendix 1 for definitions), notification is to be carried out by a CNO and accompanying Officer. When tasked to do so by JCCC, the RNCC is responsible for nominating and CNOs. Where a casualty is III or UL, it may be appropriate for the Unit to KINFORM, but it is to seek advice from JCCC/RNCC prior to doing so.

c. **Self KINFORMING.** Self KINFORMING is the process whereby a casualty notifies their own EC/NOK, giving details of their injuries or illness. **Self KINFORMING should NOT be the default approach.** This procedure may only be permitted in extremis, when all the following criteria are met. If **any** of these criteria cannot be achieved, KINFORMING is to take place through the RNCC:

(1) The casualty is categorised as UL only.

(2) The casualty is supported by medical staff at their side who are confident the casualty has sufficient knowledge of all the relevant aspects of their injury/illness.

(3) The casualty has been briefed on the potential impact of self KINFORMING on their EC,and is content to proceed.

(4) The Unit is not currently under Op MINIMISE (if on Operations), ‘RIVER CITY’ restrictions (for RN) or there are multiple casualties. In these circumstances, the unit at home can better coordinate notifying duties and prevent the broadcast of misinformation amongst NOKs.

d. The result of Self KINFORMING should be debriefed by the casualty’s immediate CoC to the JCCC.

e. **Mass Casualty Incident.** JCCC will liaise with the RNCC and potentially activate the Royal Navy Casualty Activation Centre (CAC). In the event of a multi-Service incident, the JCCC may activate the Major Incident Centre (MIC); each incident will be managed on an individual basis.

4. Emergency Contact/Next of Kin Information

The effectiveness of the notification process is dependent on the accuracy of the information available to CNOs. Recent incidents have disclosed serious inaccuracies in EC/NOK information recorded on JPA. This has the potential to cause great distress to the families of casualties and significant embarrassment to the RN.

5. Media 'Lines to Take'

Navy Media is the lead agency for generating Media Lines to Take (MLTT) for any RN casualties. The RNCC will liaise with Navy Media regarding all RN casualties.

6. Summary

a. It is imperative that all Ships, Units and Establishments have a robust system in place to ensure that the RN Notification Process is understood and followed.

The importance of the accuracy of EC/NOK information held on JPA cannot be over emphasised and it is a fundamental DO/LM responsibility to carry out regular checks to ensure that information is current.

b. The lead on all casualty related actions within a Ship, Unit or Establishment lies with the Executive. Duty Officers should familiarise themselves with the process and all Duty Officer packs should contain a copy of this Directive. The RNCC Duty Casualty Officer is available at any time to provide advice and guidance.

APPENDIX 1 TO ANNEX 24H

RN NOTICAS - MANDATORY REQUIREMENTS

1. RN NOTICAS signals are required for any of the events listed below:

a. **Deaths.** For a death to be notified there must be no doubt whatsoever as to the fact. Whenever there is the slightest question whether death has occurred e.g. where a Service Person (SP) is believed to have drowned, but the body has not been recovered and identified, the casualty must be notified as either 'Missing – Believed Killed (MBK)' or 'Missing Not Known (MNK)'.

b. **Missing and Returned from Missing (RFM).** Missing includes kidnapping and detention by a foreign power but not illegal absence e.g. AWOL.

c. Casualties Medically Categorised as:

(1) **VSI.** A patient is listed 'very seriously ill' when their illness or injury is of such severity that life is imminently endangered.

(2) **SI.** A patient is listed 'seriously ill' when their illness or injury is of such severity that there is cause for immediate concern but there is no imminent danger to life.

(3) **III.** A patient is listed with an 'Incapacitating Injury/Illness' if illness or injury does not warrant classification as VSI or SI, but renders them physically and/or mentally incapacitated.

Any casualties categorised as VSI, SI or III are not permitted to SELF KINFORM.

d. **Unlisted Casualties (UL).** A SP whose illness or injury requires hospitalisation but whose condition does not warrant classification as VSI, SI or III.

e. **Casualties Unexpectedly Admitted to Hospital.** Casualties who are medically categorised as UL, but unexpectedly admitted to hospital in the following circumstances must be reported to JCCC:

(1) On duty away from their home base; on operations, overseas deployments or exercises.

(2) On board HM ships at sea or away from home ports.

(3) Casualties admitted to hospital for less than 72 hours, but injuries caused by circumstances that would be of public interest e.g. personnel Wounded in Action (WIA).

(4) Admissions exceeding 72 hours; these must be reported by NOTICAS with effect from the date and time of admission.

(5) Other occasions where the reporting unit or individual is unable to notify the EC directly and requires the assistance of the JCCC.

f. Casualties whose injuries are believed to have been caused as a result of deliberate self-harm/attempted suicide and who have not been otherwise listed should be reported as UL.

g. Previously reported casualties whose casualty state or location has changed.

h. Previously reported casualties once declared FIT and discharged from hospital.

i. Whenever injuries or illness cause a SP under the age of 18 years to be admitted to hospital, their NOK are to be notified unless the patient asks for them not to be. If their injuries or illness are not in themselves notifiable, their wishes may be disregarded if the hospital authorities consider that it is essential or in the patient's best interest to inform the NOK, provided that their Commanding Officer's agreement has first been obtained.

j. There is no requirement to report personnel if temporarily attending or admitted to hospital for less than 72 hours, if away from their home-base, for minor medical conditions that do not require AEROMED evacuation. Similarly, if in the opinion of a medical officer, personnel were at their home-base and treated by Role 1, followed by a period of sick leave.

2. Casualty Reporting[1] Categories

Casualty Details (Category/Status). Serial CHARLIE of the NOTICAS must show one of the following categories for each casualty:

DEAD	
KIA	Killed in Action. A battle casualty who is killed outright or who dies as a result of wounds or other injuries before reaching a medical treatment facility
DOW	Died of Wounds. A battle casualty who dies of wounds or other injuries received in action, after having reached a medical treatment facility
DNK	Dead Cause Not Known
DOP	Died on Operations - (Died, when deployed on Operations, or as a result of Operations, but not KIA or DOW)
NOD	Non-Operational Death – (Died when NOT deployed on Operations)
MISSING	
MBK	Missing Believed Killed
MBW	Missing Believed Wounded
MBPW	Missing Believed Prisoner of War
MBDAW	Missing Believed Detained Against Will
MNK	Missing Circumstances Not Known/Not Accounted for NOM Non-Operational Missing
CPW	Confirmed Prisoner of War
DAW	Detained Against Will
RFM	Returned From Missing/Detained

[1] In the context of casualty reporting, personnel who are categorised as 'on operations' are deemed to be engaged in combat, including movement, supply, attack, defence and manoeuvres needed to gain the objectives of any battle or campaign. Normally this would be characterised by the presence of belligerents, designation of an operational area, and the generation of CDS's Directive.

MEDICAL LISTING	
VSI	Very Seriously Ill/Injured/Wounded
SI	Seriously Ill/Injured/Wounded
III	Incapacitating Illness/Injury
UL	Unlisted Condition
MI	Minor Injury (Does not warrant hospitalisation. Only for use in the event of high-profile multiple casualty incidents when details of all personnel involved are required)
DFH	Discharged From Hospital
OK	OK (For use in the event of high-profile multiple casualty incident when details of all personnel involved are required)
FIT	Fit

3. Supplementary Information. Serial ECHO of the NOTICAS should include as much of the following as is known:

CAUSE	
E	Enemy Action/Fire
F	Friendly Action/Fire
OA	Operational Accident (An accident occurring when deployed on Operations)
NOA	Non-Operational Accident (An accident occurring when NOT deployed on Operations)
RTA	Road Traffic Accident
NC	Natural Causes
VUC	Violent or Unnatural Causes
PLUS (Only If Applicable) NBC CATEGORY	
N	Nuclear
B	Biological
C	Chemical

4. Supplementary Medical and Management Information. Serial ECHO of the NOTICAS is to also include one of the following:

MANAGEMENT INFORMATION	
WIA	Wounded In Action (On Operations)
NBI	Non-Battle injury (On Operations)
NOI	Non-Operational Injury/Illness (NOT deployed on Operations)
IDC	Identity Confirmed
IDP	Identification Provisional
Duty	Duty
Off Duty	Off Duty
Res	Reservist

APPENDIX 2 TO ANNEX 24H

NOTICAS EXAMPLE

Precedence - Action - IMMEDIATE

DTG 280555Z FEB 21
From: 45 Cdo RM
To: JCCC INNSWORTH

SIC: ABA/WAL

NOTICAS

A. INITIAL
B. CPL, JD (JOHN) EVANS, ROYAL MARINES, 12345678, 45 COMMANDO RM
C. DEAD
D. 280330Z FEB 21, ON A303 NEAR ANDOVER, WILTS
E. RTC, OFF DUTY, REGULAR
F. RIDING CIVILIAN MOTORCYCLE, IN COLLISION WITH LORRY
G. MULTIPLE INJURIES. MEDICAL CONTACT DR JAMES, A&E DEPT, ANDOVER HOSPITAL 01980 123456
H. ANDOVER HOSPITAL AT 070550Z
I. KINNOTFORMED. EC MRS MARY EVANS, 15 RIVER ROAD, NEWTOWN, BUCKS, BT8 3RF
J. ACCIDENT IS SUBJECT TO POLICE INVESTIGATION. UNIT POC CAPT P SMITH ADJT 45 COMMANDO RM 01234 12345678

APPENDIX 3 TO ANNEX 24H

NOTICAS TEMPLATE

1. NOTICAS Format

The text of a NOTICAS message is to begin with the word 'NOTICAS'. If more than one casualty separate NOTICAS messages are required. Thereafter the following format is to be used:

Precedence - Action - IMMEDIATE

DTG Month Year
From: Unit
To: JCCC INNSWORTH

SIC: ABA/WAL

NOTICAS

ALPHA (Essential)	State "Initial" Report or "Update" with Update number.
BRAVO (Essential)	Rank, Initials (and known forename), Surname, Service (RN, RM, Army, RAF, etc.), Service Number, Unit, (and attached Unit if applicable) NB: For a dependant give the name of the casualty then the relationship and details of the service person (e.g. wife of …)
CHARLIE (Essential)	Casualty Category Details (Category/Status) (e.g. Dead, Missing or Medical Listing. See categories at Annex A), also Previous Category if an 'Update' (e.g. VSI previously SI).
DELTA	Date and Time of the incident and Place (if known and not classified).
ECHO	Supplementary Information. Include Cause, On Duty or Off Duty, Regular or Reservist and any of the supplementary management information categories in Annex A that apply.
FOXTROT	Cause Categorisation. Free text showing additional details about the incident. Include rank, name and number of any other military personnel involved. For categories see Appendix 1 to Annex 24I.
GOLF	Supplementary Medical Information. Details of injury or illness if they can be released, otherwise a medical contact who can provide information for the Emergency Contact (EC) or Casualty Notification Officer (CNO).
HOTEL	Casualty Location at Date and Time (use DTG).
INDIA (Essential)	State whether the Emergency Contact (EC): Has been informed - use Codeword **KINFORMED** The unit will inform - use Codeword **KINFORMING** JCCC to inform - use Codeword **KINNOTFORMED** Where KINFORMED, state who has been informed. In all cases include Name, address and relationship of EC if known. Also any other information regarding the EC that will be useful for the CNO.
JULIET (Essential)	Additional Remarks. Any additional known facts that will be useful for the CNO/VO, RCDM and Parent Unit (e.g. Requirement for DILFOR, specific Welfare requirements, Date and Time of Death if different from Date and Time of incident). This must include the name and telephone number, both working and out of hours of a Unit Point of Contact (POC).

2. Everything in The NOTICAS Must Be Factually Correct.

If the reporting unit is not certain this must be identified in the text (e.g. Witness reports casualty has been taken to “x” hospital). Reporting units must aim to provide all the required information. When speed is essential, however, or when to find out all the information would incur delay, reporting units must send an Initial NOTICAS with at least the essential information indicated above.

a. If an Initial NOTICAS is sent without some of the required information an update must be sent as soon as possible, so that the family members can be fully briefed.

b. All times are to be in ZULU.

APPENDIX 4 TO ANNEX 24H

RN NOTIFICATION - STEP BY STEP GUIDE[1]

UNIT ACTION

- Incident occurs resulting in a casualty. Unit phones JCCC 01452 519951 to pre-warn of incoming NOTICAS.
- If required, contact RNCC 07770863079 for guidance and to alert.
- 20U NOT to be raised until **after** the NOTICAS has been actioned.

UNIT ACTION

- Raise NOTICAS on JPA and submit to JCCC immediately. If no access to JPA, e-mail NOTICAS format to dbs-jcccgroupmailbox@mod.gov.uk
- **Accuracy of information is paramount.**
- Consider Op MINIMISE or similar until KINFORMING has been completed.
- Do not delay for lack of information.

JCCC ACTION

- JCCC confirm NOTICAS details and forward to the NA (RNCC).

RNCC ACTION

- If KINFORMING is required, identify and activate CNO Team.
- Liaise with Duty Chaplain.
- Liaise with RN FPS to nominate a VO.
- Inform wider RN community iaw SOP.
- A VO will be allocated to all casualties listed as SI or above (except in a Mass Casualty Incident).

CNO Team

- Conduct KINFORMING and once complete report to JCCC and RNCC.

JCCC:

95471 7325 / 01452 519951

RNCC Duty Casualty Officer (DCO)

07770 863079

A NOTICAS is to be raised in the following circumstances:

1. If casualty is listed as UL and has been admitted for more than 72hrs.
2. If the casualty is on duty away from their home base, on operations or involved in overseas deployments and exercises.
3. On board HM Ships at sea or away from home port and **admitted** to hospital.
4. If there is, or is likely to be public interest.
5. If the casualty has been admitted to hospital and requires Aeromedical evacuation.
6. If it involves self-harm or attempted suicide.
7. If the casualty is under 18 years of age.

The RNCC will inform the Chain of Command of on-going situation as per RNCC Reporting Guidelines.

A VO will be allocated to all casualties listed as SI or above (except in a MCI).

[1] This is an overview of the process; JCCC/RNCC actions may vary depending on casualty listing.